DOCUMENT RESUME

ED 084 253 SP 007 489

AUTHOR Gilmore, Robert
TITLE Drug Education Handbook.
INSTITUTION Colorado State Dept. of Education, Denver.; Colorado State Dept. of Health, Denver. Div. of Alcoholism and Drug Dependence.
PUB DATE Sep 70
NOTE 142p.
AVAILABLE FROM Alcoholism and Drug Dependence Division, Colorado Dept. of Health, 4210 East 11th Avenue, Denver, CO 80220 ($1.50)

EDRS PRICE MF-$0.65 HC-$6.58
DESCRIPTORS Bibliographies; *Counseling; *Drug Abuse; *Drug Education; Glossaries; *Health Activities Handbooks; Health Books; Health Education; *Teacher Education; Vocabulary

ABSTRACT

This handbook on drug education is divided into nine sections. Section 1, An Approach to Drug Education, proffers information and advice on such subjects as student ploys, confidentiality, and student questions about marijuana vs. alcohol. Two major ideas in this chapter are that drug education should be integrated into the total curriculum and that one should not try to teach dogmatic and categorical facts about drug abuse. Section 2, Understanding the Student, contains four essays by different authors on adolescence and the problem of drugs. Section 3 is a glossary of technical terms; Section 4, a glossary of drug jargon and slang terms. Chapter 5, Drug Information, contains material on the abuse of specific drugs and their effects. Section 6 is a brief chapter on legal aspects in drug education (federal and state statutes in general). Section 7 is a discussion of problems of abuser identification and referral. The Conclusion, Section 8, advocates full health education courses for every community and increased training of teachers as early detectors and case finders. Section 9 is a bibliography of comprehensive bibliographies, basic books and pamphlets, and films. (JA)

FILMED FROM BEST AVAILABLE COPY

ED 084253

DRUG EDUCATION HANDBOOK

U S DEPARTMENT OF HEALTH,
EDUCATION & WELFARE
NATIONAL INSTITUTE OF
EDUCATION
THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

PREPARED BY

ALCOHOLISM AND DRUG DEPENDENCE DIVISION
COLORADO DEPARTMENT OF HEALTH
4210 EAST 11TH AVENUE
DENVER, COLORADO 80220

IN COOPERATION WITH

COLORADO DEPARTMENT OF EDUCATION

SEPTEMBER 1970
PRICE: $1.50

SP 007 487

ALCOHOLISM AND DRUG DEPENDENCE ADVISORY COMMITTEE

COLORADO DEPARTMENT OF HEALTH

Mildred Doster, M.D., Chairman
Denver

Judge William Burnett, Vice-Chairman
Denver

Graydon Dorsch, Secretary
Denver

Carl L. Anderson, Ph.D.
Denver

Senator Roger Cisneros
Denver

Henry E. Cooper, M.D.
Denver

William A. Davis, M.D.
Grand Junction

Edward J. Delehanty, M.D.
Denver

Mrs. John L. J. Hart
Denver

Sister Myra James
Colorado Springs

John F. Kelly, M.D.
Denver

Judge Samuel M. Kirbens
Denver

Jordan R. Moon, Detective Sgt.
Golden

James O. Parker
Denver

Mrs. Virgil C. Smith
Alamosa

Senator Ruth Stockton
Lakewood

Robert Weiland, Ph.D.
Lakewood

Consultants

Roy L. Cleere, M.D.
Denver

C. Wesley Eisele, M.D.
Denver

Hans M. Schapire, M.D.
Denver

ACKNOWLEDGMENT

This handbook was prepared in response to numerous requests for such material by school and community groups. It was compiled by Robert Gilmore, Coordinator of Community Education, Alcoholism and Drug Dependence Division, Colorado Department of Health, working in cooperation with the Department of Education. Pre-testing in selected classrooms in the Denver Public Schools was arranged through Louise McNiff, Supervisor, Health Education.

The help of many dedicated and concerned persons in developing this handbook must be acknowledged: Mildred Doster, M.D., Assistant Director of Health Services, Denver Public Schools; John Thompson, Ph.D., Health Education and Safety, State Department of Education; and V. Alton Dohner, M.D., formerly Fellow in Pulmonary Diseases, University of Colorado Medical Center.

Appreciation is also due to Allan Cohen, Ph.D., Consulting Psychologist, University of California; Sidney Cohen, M.D., Director, Drug Research, National Institute of Mental Health; Kent Jordan, M.D., Professor of Child Psychiatry, University of Colorado Medical Center; and Kenneth Wells, Executive Officer, Boy Scouts of America, for graciously permitting the publication of their monographs. And a special thanks is due to Martha Maul, who, as a volunteer, contributed a monumental amount of research and proofreading.

Assistance in planning community education programs is available from the staff of our Department's Alcoholism and Drug Dependence Division, Graydon Dorsch, Director.

Roy L. Cleere

Roy L. Cleere, M.D., M.P.H.
Executive Director
Colorado Department of Health

CONTENTS

I An Approach to Drug Education 3
  Teaching About Drugs 4
    Weekend Encounter Group 17

II Understanding the Student 23
  "Psychosocial Development of Adolescents,"
    by Kent Jordan, M.D. 23
  "The Adolescents' Dilemma,"
    by Kenneth A. Wells 33
  "Inside What's Happening: Sociological, Psychological, and Spiritual Perspectives on the Contemporary Drug Scene,"
    by Allan Y. Cohen, Ph.D. 42
  "Information and Misinformation About Drugs,"
    by Sidney Cohen, M.D. 48

III Glossary (Technical Terms) 55

IV Drug Jargon (Slang Terms) 63

V Drug Information (Drugs of Abuse and There Effects) . . 81

  1. Introduction 81
  2. Narcotics 83
  3. Depressants and Tranquilizers 84
  4. Stimulants 87
  5. Psychedelics or Hallucinogens 91
  6. Marijuana 95
  7. Miscellanious Drugs of Abuse 99
  8. Profit Motive 103

VI Legal Aspects 107
Colorado Revised Statutes (CRS 1963), Article 5,
Narcotic Drugs 109
Narcotics and the Juvenile 111
Federal and State Statutes on Drugs 112

VII Problems of Abuser Identification and Referral 117
Drug Abuse and Misuse -- Problem of Identification . . .118
Common Symptoms of Drug Abuse 120

VIII Conclusion: Where Do We Go From Here? 127

IX Bibliography 133
A. List of Comprehensive Bibliographies . . . .
B. Basic Bibliography of Books and Pamphlets . . .
C. Films . . . .

INTRODUCTION

A Perspective on the Drug Problem and The Limitations of This Handbook

Although the mass media have kept us aware that many new and exotic substances are being abused by youngsters, we must keep in mind that the drug ethyl alcohol (ethanol) in alcoholic beverages is still the most widely abused substance in America today, and that the abuse of all other substances combined does not begin to cause the deaths, broken homes, ruined lives, or property damage that result from the abuse of alcohol. The statistics on narcotics addicts versus alcoholics serve to give us the proper perspective in terms of relative abuse: there are approximately 60,000 narcotic addicts in the U.S. and approximately the same number of alcoholics in Colorado. This is not to minimize the seriousness of narcotic addiction; it is a dreadful thing, but compared to the 20 million lives affected by the 6 million alcoholics in this country, it is relatively less significant.

Another point influencing our perspective is that less than 5% of our young people are seriously involved with dangerous drugs. The overwhelming majority of our young people are bright, concerned, wholesome youngsters who deserve to know the facts about dangerous drugs.

For years we have been making educated guesses as to the amount of drug use among students. Althought we do not yet have an accurate means of determining drug usage among public school adolescents, a survey* has been made by the Department of Psychiatry at the University of Colorado Medical School to determine drug usage by the college students of Colorado. Interestingly, the figures contained in this study tended to corroborate the estimates we had made: LSD use was declining, marijuana use was increasing, and amphetamine (speed) use was about one-half that of marijuana. Of the total sample of 7,810 students who reported at least one-time drug usage, 16% had at least once in their lives used amphetamines without a doctor's prescription, 26% had used marijuana, and 5% had used LSD. These figures represent reported lifetime usage, not current usage, and are indicative that the exaggerated estimates that we so often read about are based on fear and lack of information.

---

*"Patterns of Drug Use Among College Students," published in draft in May 1969.

In the handbook which follows, no claim is made to having supplied all the answers to all the drug problems which those who work with adolescents will encounter. Rather, the material presented is intended as a basic resource guide, a place to start when information is needed about drugs and their abuse.

The booklet contains the basic pharmacological information about the types of drugs most commonly abused, but if more detailed information is required on a specific drug, a physician should be consulted. Material is included which explains in general the rationale behind adolescent drug use, but again, specific problems should be referred to those best qualified to deal with the problem, e.g., the physician, nurse, social worker, counselor, etc. The jargon section is as complete as we could make it, but it is to be expected that new words will be in vogue (and others dropped) before this guide is published.

We hope that you will find the material presented helpful and stimulating.

AN APPROACH TO DRUG EDUCATION

I

I

AN APPROACH TO DRUG EDUCATION

The major emphasis of any drug education program should be on putting the "drug problem" in perspective. As things stand now, the mass media have focused our attention on the younger generation and its use of the new substances, which are often referred to as the "glamour drugs." This false impression must be overcome by sound teaching. Teachers must think through the problem and become intellectually and emotionally convinced that the drug problem is not a problem of young people and drugs, but the problem of a life style of an entire society, young and old alike. Students must be made aware that ours is a drug oriented culture, not through preaching or stern lecturing, but by the simple recounting of the basic facts.

These basic facts which describe the drug oriented society should be given to students:

1. As a nation, we self-prescribe and self-administer over two million aspirin tablets daily.
2. There are over 13 billion doses of stimulant and depressant drugs legally manufactured in this country annually.
3. Alcohol is the most widely abused drug in America today, taking a toll in human life, broken homes, disease, ruined lives, and property damage that far exceeds the total cost of abuse of all other drugs combined.

4. In nine large Colorado cities, 50-75% of the arrests in 1968 were alcohol related. 30% of the admissions to the Colorado State Hospital and 46% of the admissions to Ft. Logan Mental Health Center in the last three years have been as a direct result of alcoholism.
5. Only about 3% of the estimated 60,000 alcoholics in Colorado are of the familiar "skid-row" population.

TEACHING ABOUT DRUGS

We should give serious thought to taking the focus off drug abuse education as a separate entity and urge school people to include it along with sex education, venereal disease, alcohol and tobacco education and all other health concerns in "life education" section of the total curriculum. Such an approach would put all these emotional subjects into proper perspective and avoid focusing undue attention on one area (usually the one that is getting the most news publicity). Such an approach would avoid the possibility of the "seduction" of the curious, and requires the best efforts of all of us in opening communications with the younger generation.

Today, however, if Dr. Yolles, the former director of the National Institute of Mental Health, is correct in his prediction that drug abuse will increase 100 fold in the next ten years, we are indeed approaching a time of crisis in drug education. Until the "drug problem," like other areas of health education, is integrated meaningfully into the total curriculum, it will continue to be taught in a fragmented way by volunteer teachers. The following material is based on trial and error and experimentation with a variety of approaches in the hope that teachers will find it helpful.

The first has to do with the apparent conflict in the data and research being reported on drugs and their potential for damage, especially marijuana. We must wait until the current studies of long-term use are completed and reported before we have a definitive scientific basis on which to take a stand. Teachers should equip themselves with the basic facts about the substances of abuse. This does not constitute a large body of knowledge, especially when the half-truths, myths, and misconceptions are discarded. Much of our "scientific" drug knowledge is actually extremely unscientific, inadequately researched, and poorly reported. Effective drug education may be expressed in an essentially negative manner: Do not try to teach dogmatic and categorical facts about drug abuse. Rather, keep in mind that all drug effects, and this includes legally prescribed substances no less than the illicit substances, depend on many variables such as dosage and purity, the physical and psychological state of the person taking them, and the environment in which the drug is taken.

With this in mind, teachers, who feel confortable in doing drug education can face their classes with confidence. The following material is offered in the hope that it will prove helpful to teachers in answering the most common concerns and disputes of students.

Marijuana vs. Alcohol

We must not be caught up in the popular and probably interminable controversy over "which is worse, alcohol or marijuana?" This sort of argument is useless and often nothing more than an exercise in sloppy semantics, fraught with generalizations and undefined terms. Since this is one of adolescents' favorite arguments, it should be handled, when it comes up, as honestly and openly as possible based on what is known. First, the abuse of any substance, whether it be food, tobacco, alcohol, marijuana, or any other drug is a symptom that things are not right within the abuser. He is choosing an unhealthy way to deal with the stresses and tensions that are so much a part of adolescence, and abuse of any substance should be viewed as an unhealthy way of handling the troublesome problems of interpersonal relationships.

A youngster who is using marijuana purely out of curiosity and whose adjustment to normal adolescent tensions is relatively healthy and normal, is probably not experimenting with as much risk of becoming potentially drug-involved as is his peer who uses alcohol or tobacco in a more symptomatic sense.

Any discussion of marijuana vs. alcohol must be based on a thorough understanding of the terms used about both drugs. Local marijuana is as far from hashish as 3.2 beer is from 190° alcohol, with concomitantly dose-related effects. If we can accept the surveys of drug use among adolescents, we are obliged to refrain from equating the youthful marijuana user with the stereotypes of "dope fiend" or "narcotic addict."

Adolescents, when they express themselves about why they use marijuana, will say things such as "Mom and Dad drink, so it wouldn't bug them if I did, but 'pot' scares them to death. Smoking 'pot' bugs my parents and gives me kicks."

Adults would do well to remember that smoking marijuana, like using most mood altering substances, is often a pleasurable experience. All the widespread use of marijuana is not based on adolescents' acting-out their hostilities toward parents and authority; certainly much of it is used for the pure pleasure it gives. Eighty million people in the U.S. drink alcohol; six to eight million of them are alcoholics. Millions of adolescents try marijuana; a few thousand of them will become drug addicts.

Dr. Louis J. West gives this advice: "The current proponents of marijuana are severely handicapped by lack of sufficient information about the long-term effect of tetrahydro-cannabinal (the principal active component of cannabis) upon the brain. The next few years will bring a flood of new data about marijuana (pot, grass, weed, boo, reefers, Mary Jane, kif, bhang, hashish, etc.). Good advice for youngsters today might be:

1. Just because alcohol is bad, marijuana isn't necessarily good.
2. Just because the present law is absurd, marijuana shouldn't necessarily be uncontrolled by law.
3. Just because you've been lied to about its dangers, marijuana isn't necessarily harmless."

The second has to do with being honest, low key, non-judgmental with those you deal with; with feeling comfortable when you don't know or when you have to say it. Giving opinions and separating them from facts, which you should be prepared to support.

Do not be threatened by being asked for an opinion on how you feel about something. Adolescents will test us constantly, testing for our reaction to something intended to startle us and evoke a shocked response.

Youngsters do not expect us to know and use all the latest drug and hip expressions and jargon. Rather, they like to use it to test our reactions and to feel "one-up" and superior when we don't "dig." There is a "mystique" to all this that is not sufficiently understood. We often shut off communication when we respond in a threatened manner and launch into a lecture or scolding attack on them, their styles of dress and talk, etc. The best response is still a cool and reasonable one that does not close the door to further discussion.

Students' Ploys

In addition to wanting to compare alcohol and marijuana, students frequently will attempt to put teachers on the defensive about adult use of alcohol. Honesty is always the best response here, too, since alcohol is the "adult drug of choice" in the same sense that marijuana is the young people's. Teachers should admit that society is baffled by the alcohol problem but should not become defensive about the complexities of its legality, economic influence, and revenue producing qualities.

Students will often question a teacher about the teacher's drug use. Such expressions as "if you haven't tried it, don't knock it" are often heard. This ploy is best met with honestly and hopefully a positive indication that the teacher is getting enough out of life or that he or she does not feel the need for mind altering substances. More study and research need to be done on ways to live a full and satisfying life without drugs, and the "natural trip" and "non-drug turn-ons" are being explored as healthy alternative behaviors.

The Drugs

Experience has indicated that we have wasted a great deal of time and effort in traditional anti-drug abuse education, lecturing, showing films, etc. Along with this approach has gone an over-emphasis on the drugs and their effects. This factual material (and the facts are relatively few), should be presented and discussed briefly, leaving as much time as possible for the more important question of -- WHY? Why does a person feel he needs drugs, and what influences are at work in his life that make him feel inadequate to deal with life problems without the aid of mind or mood altering substances? These considerations require a dialogue, a give-and-take setting, certainly not the lecture-film format. To simply tell people impersonally of the potentially harmful effects of some drugs is not adequate education. Rather, we should approach the subject from the personal point of view (unique to every individual) of his emotional attitude toward drugs, and if he happens to be an abuser, seek an answer to why he is. Available research indicates that the real understanding of the drug scene is not to be found in the pharmacological properties of the drugs, but rather by turning to personality theory and social psychology and attempting to understand the uniqueness of every individual and why he feels he must use drugs.

Youngsters are apt to say things like "Drugs are where things are real." Or, "When I use drugs I can bug my parents and do my thing at the same time." They will often give as their justification for using drugs the hypocrisy they feel the older generations practice and the existence of the so-called "generation gap." These things can be discussed, but teachers should be advised against becoming involved in a discussion of specific drugs and their "effects." Rather efforts should be made to get to why the need to use drugs at all. Behind almost every drug abuser is a serious problem, such as a disordered home, one or more alcoholic parents, etc. These are the things which must be talked about and the youngster led to identify the alternatives and options available to him. Such counseling on an individual basis is not, unfortunately, possible in most schools. and is not a component of the basic drug education most teachers will be doing. It is mentioned as a recommended essential follow-up which should be available to every student who wants it.

As Dr. Barter* has said, we as adults and educators should keep in mind that some drug use, such as smoking marijuana, is "fun and pleasurable." If this were not so, the drug would not be so popular and its use would not be increasing so rapidly. Users, especially adolescents, are keenly aware that adults are not inclined to see or admit to any good about the drugs adolescents use. This is evidenced by users who are impatient with non-users, saying in effect, "How can you know if you haven't tried it?"

---

*Dr. James Barter, formerly Assistant Director, Colorado Psychiatric Hospital, Denver, Colorado.

Groups

Working with small groups is preferable because only in this setting can we find out where in reference to drugs those we wish to educate are emotionally. Small groups are infinitely better than large. As Dr. Sidney Cohen of the National Institute of Mental Health said: "Small groups are more effective than large groups, and one-to-one transactions have the greatest impact of all." In small groups, even unstructured, students are more apt to express their feelings and concerns than in larger gatherings. In more formally structured settings, some amazing things have happened that may be opening new doors to meaningful drug education. Such things as encounter* and sensitivity groups are becoming increasingly popular and offer exciting challenges for the future.

Confidentiality

Teachers owe it to themselves and their students to ascertain the policy of their administration and the local law enforcement agencies in regard to how information about drug abusers is handled. Since policies are different within school districts, indeed, from one building to another, and since drug laws are subject to varying interpretations and to varying degrees of prosecution, it is sometimes the teacher's obligation to stop a student from revealing too much confidential information. If the lines of authority and communication are quite clear to both parties, this does not have to be a serious problem. It is, of course, patently unfair for a teacher to betray a student's confidence, but if regulations require that some things must be reported to higher authorities, then by all means the teacher should be sure the student knows of this requirement before he is allowed to reveal confidential matters. There are instances when a student puts a great burden on a teacher when he confides names of users and/or pushers to a teacher. This is a delicate matter, and must be handled in a consistent and honest manner. Betraying one student's confidence will insure that the teacher who does so will not be given subsequent opportunities to help other students. Making the school's policy clear in advance will usually prevent serious misunderstandings.

---

*Description of a weekend encounter group follows.

Alternatives

Young people are constantly searching for alternatives to drug use, and it becomes the duty of the older generation to help them in their quest. Dr. Allen Cohen's experience in counseling hundreds of college youth at Berkeley convinced him that people will cease drug use when they discover meaningful ways to achieve satisfaction in life without drugs. As an ex-user, Dr. Cohen speaks with authority when he says: "The hidden ally here is the ultimate failure of drugs to fulfill the real needs of the users. If drugs did work, we might as well scrap any countermeasure."

Someone has said that there are only three activities which have a thrill and risk-taking value comparable to drug taking: skiing, mountain climbing, and sky or scuba diving. Obviously these pursuits are not available to most of our young people, nor are they necessarily appealing to everyone. These "alternatives" are not to be taken so literally as to conclude that youth will accept only those alternatives which have a risk-taking component equal to that provided by drugs. Rather, we should view the drug experience in terms of the very real dangers youth seek in the three activities. For many young people risk-taking and inviting death or injury are "where it's at" in their effort to escape boredom, assert their individuality, impress peers, prove something to themselves, and similar motivations. To approximate the drug experience, alternatives must meet certain criteria. Arnold Chanin, M.D., has explored the area of meaningful alternatives to drug use. He says: "The alternatives to drug use is simply not to use them. But to the inquisitive teenager exposed to temptation, this is not sufficient reason to stop experimentation." Chanin describes four criteria which alternatives must meet: (1) They must be in the realm of the intuitive, not the rational. This explains why some of the Eastern religions, Yoga, and meditation have gained popularity with many young people. (2) They must involve active participation and involvement. In this area we can identify the anti-war protests, population control movements, demonstrations of various types, and probably establish a correlation between this criterion and the passive nature of much formal education. (3) They must provide a feeling of identification with a larger body of experince. This would encompass the creative and dramatic arts, especially music.

(4) They must not be directly concerned with day-to-day routines, such as job or education. This would account for the fact that many youth do not derive the sense of reward and accomplishment, especially from routine and repetitious work, that their parents feel they should. It is significant also that many young people abuse drugs while carrying on satisfactorily on a job or at school. Those areas which seem to provide vital and pertinent alternatives to drug use are: (1) the creative and aesthetic; (2) the religious - philosophical; and (3) social involvement.

Creative and aesthetic experiences: young people should be encouraged to approach the creative experience in two ways, through appreciation of artistic work and through active creation. Through the creative process, a teenager can give his life experience objectivity and permanence. The world of creative arts is a vital and relevant area in which to pursue the imaginative experience.

Social involvement: the area of social and political involvement appeals to youth because of its inherent commitment to an ideal. Young people today are generally highly idealistic and have strong social consciences. They seem to be able to maintain their idealism in the face of very strong opposition and even attack, especially in anti-war idealism which springs from a strong conviction in so many cases. Such involvement is meaningful only so long as individual identity is maintained.

Religious, philosophical involvement: this is an area of great concern to today's generation. Without providing definite answers, it involves a deepening search for meaning on a personal and universal level.

It may end with an affiliation with an established religious group, or a wholly personal philosophy. The Eastern and occult religions, including Zen and Hinduism are gaining many practitioners among the youth of today, as is interest in the mystical and magical. Reverence for gurus, alchemy, karate, Japanese archery, graphology (the study of character through handwriting), astrology, involvement in encounter, sensitivity, and a wide variety of discussion groups - all have sizable numbers of devotees and are all potentially alternative forms of interest and behavior from which many young people can attain "natural trips." Groups are effective because they allow for real and open communication and for getting involved. The practice of meditation, Yoga, efforts to attain self-awareness, fasting, and other esoteric practices are gaining popularity as ways of turning on without drugs. Many young people are discovering a "new Christ," and many are turned on by the humanistic teachings of this gentle man who preached and practiced non-violence. In many cases, the resultant affiliation or commitment is not to the church, which they may see as too "establishment" to provide the appropriate setting in which to practice their form of Christianity. Much is to be said for the dialogue which evolves with others similarly concerned.

When the adolescent or young adult feels that ethical or moral problems are ignored or avoided by the older generation, he feels alone and alienated. Especially when he feels that these problems are exclusively his, and he begins to come to grips with the fact that there are no concrete answers. In counseling such young people, adults should reassure young people that many of their intelligent questions are also of equal concern to many intelligent older persons. Realizing this, the youngster does not feel so isolated. As he matures he can then integrate the thoughts of others into his own personal philosophy.

As adults and teachers, we must constantly examine our own attitudes to be sure that we are not as threatened by young people's desires to get involved as we are by their desire to drop out. All adults are urged to give serious thought to discovering and developing more ways for young people to use their energy, enthusiasm, and intelligence in challenging and rewarding endeavors.

Weekend Encounter Group

This group meeting was called "An Intensive Drug Education Laboratory." Most of those who attended expected a formal "workshop" presentation and expected to participate primarily as receivers of information. We were wrong.

The groups consisted of eight adolescents, most of whom were dressed and wore hair styles suggestive of a "hippie" orientation, and approximately 50 adults, mostly teachers, with a few administrators, counselors, school nurses, parents, and other professionals added. Beginning Friday evening at about 7:00, the group assembled for a brief orientation. This brief session comprised all the conventional structure that would be drawn for the weekend. The group then divided into small groups, each containing at least one adolescent. Some of these groups met far into the early hours of Saturday morning. It should be mentioned here that some of the groups stayed in session all night on both Friday and Saturday nights.

On Saturday morning when the total group assembled, it was apparent that some of the participants had had a personal experience. It was equally apparent, however, that most of them, adolescents as well as adults, had really felt nothing because the younger group evidenced mistrust toward the adults, and the adults were quite obviously uncomfortable with the young people. Some demonstrated their discomfort by avoiding the young people, other by non-verbal disapproving glances, and other by simply ignoring the young people. Several adults expressed discomfort at being in the large group and asked that they be allowed to break into small groups again. The leader of the weekend activities, who throughout the session maintained a totally non-directive approach, did not yield to these requests. Rather, he asked the young people to sit in an inner circle and the adults to sit around them in a larger circle of two or three rows. The process was one of give and take, questions and answers, open discussion. A few questions about drugs were asked, most of which were answered by a health educator (drug program coordinator) and a psycho-pharmacologist. Gradually, the momentum of the group began to move off the drugs and on to people and their feelings. This was a turning point in the weekend, and it was done so subtly that no one was aware of it when it was happening. Looking back, I know now that this required great skill, patience, and technical competence on the part of the leader and the other facilitators present. They accomplished it in a non-directive way, never articulating to the group that it would or should occur.

Once the group became more comfortable on the personal level, the process of learning began. The young people were repeatedly called upon to explain why those of them who used drugs felt they needed them. The adults were beginning to show concern for the youngsters as persons rather than as possible drug users. The young people advanced many of the familiar reasons for drug use, e.g., curiosity, kicks, peer-group pressures to do the "in thing," etc. Gradually, however, the reasons became more personalized. One girl admitted that she always felt "alone and out of things." This, she maintained, was so even though she had a fairly good relationship at home. She frankly referred to the acceptance she got from her peer-group in a drug using setting as being a motivating factor in her use.

Saturday afternoon the participants divided again into small groups. Some did some very dramatic role playing, enacting such confrontations as a teenager confessing to his mother that he had used and enjoyed drugs, and a teenager being pushed from his home by an irate father. The young people participated eagerly in these sessions. Later in the day, the participants came back together. Each person who had been in the inside circle chose a person to replace him in the new inner circle. When this process was completed, the new inner circle was made up of those adults who had let the group see the least of them, those who had spoken little if at all. These new persons were then questioned by those outside the inner circle as to what the experience was meaning to them. Their answers reflected a strong reluctance to "let go" of their feelings, to share with others the doubts and concerns that others had been able to share with the group. This was a long, slow session, and not very productive on an overt level.

After supper, the group was shown two films. One, called "Rapping," featured ten high school students who informally talked about using drugs. Some had used and stopped, others had never used but were curious, and others said they would never use. It was an excellent and authentic film, not at all contrived nor sermonizing in its approach. It made a very favorable impression on the group. The other film, called "Tripping," was a series of demonstrations of ways to achieve natural "highs" or trips without drugs. The same group of high school students appeared in both films. "Tripping" was a moving and emotional film, which deeply impressed the group. Many of us plan to procure these films when they are available. Following the films, the group was led in a demonstration of some similar techniques, including a total relaxation method which resulted in the participants becoming open and suggestible to an imaginary journey through a door and into a mysterious cave. The group leader was most impressive in demonstrating and practicing what he described as "Being." To simply "Be" proved quite difficult for most participants.

Sunday morning began slowly. After several long silences, one of the teenaged girls confronted one of the adults with an invitation for him to tell her how he feels about her. The adult is able to tell her that he cannot let himself "like" her because she uses drugs. He also makes a reference to her obvious weight problem and accuses her of using drugs because "she is so fat that boys would find her repulsive." The girl responded that she felt better hearing these things from him because she had been feeling his silent disapproval all weekend. The tension between these two persons began to relax. As it did, the same lessening of tensions seemed to take place throughout the entire group, and communication came much easier for everyone for the balance of the day.

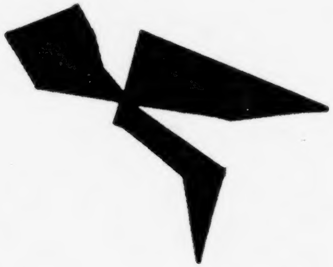
The weekend culminated Sunday afternoon when the leader, after an interval of silence, asked everyone to try as hard as he possibly could to let himself "feel the feelings" of the group. One by one at first, then in twos and threes, the adults left their seats and sat on the floor and embraced the young people. After an hour there were only about six adults who had not joined the young people on the floor. One man, who had not left his seat, was asked why he had not joined the group. He replied that he felt some adults were there because "they thought it was expected of them, that it was the thing they should do." Another, a woman, answered that she was with them in feelings, but would not feel comfortable joining them. The group on the floor directed remarks to some of those still seated. One person was told that the group was getting a good and supportive feeling from him even though he had not joined them. Several of the young people as well as the adults had an extremely emotional response to this session, frankly expressing feeling accompanied by tears and embracing.

This encounter demonstrated that beneath the facade or shell of protection that everyone builds around himself, young and old alike, there exists a need to relate to other people. The exterior styles of dress and hair, drug or substance use, age, position, and normal protective defenses seemed to melt away and lose significance as barriers between people trying to be people. It is my conviction that this experience represents the finest kind of "drug education." Insofar as more and more of us who work in the field of drug education are coming to realize that traditional didactic approaches are not working, the approach seems to be an exciting alternative. It has disadvantages, of course, such as the obvious difficulty of providing it for everyone. This, however, is a soluble problem, not inherent in the method itself. It requires skilled and competent leadership, both to achieve the desired communication as well as to handle the feelings and emotions engendered in the participants.

This approach should not be regarded as the total answer to the need for viable drug abuse education. However, it should be utilized whenever possible and added to the small number of approaches which have proven to be effective. It also begs that we continue to assess the effectiveness of our traditional methods, most of which are impersonal in their approach and thus fail to influence the attitudes and behavior of those we are seeking to help.

UNDERSTANDING THE STUDENT

II



PSYCHOSOCIAL DEVELOPMENT OF ADOLESCENTS:

IDENTITY VERSUS ROLE CONFUSION

By Kent Jordan, M.D.

Adolescence may be defined as a developmental period of accelerated psychological change, with the over-all developmental task of making a transition from a child-like to an adult-like psychological status. Adolescence here refers to a psychosocial developmental period as differentiated from the physical development period of puberty. The psychosocial and physical developmental processes are usually, but not always, closely associated in time.

Identity may be defined as those fairly stable and well defined personality characteristics of an individual which are maintained consistently over a prolonged period and set that person off as a distinct and separate individual. These characteristics taken together delineate "who" a given person basically is, as sensed by himself and perceived by others.

Before adolescence children have identities. However, the earlier childhood identities differ in many ways from the identity which emerges out of adolescence. Thus, younger children have different identities in different stages of psychosocial development; the final adolescent identity normally is more stable and is maintained in general outline throughout the remainder of the person's life. The earlier identities are much more dependent upon other people, especially parents, for their creation and maintenance; the identity which is normally achieved in adolescence is more, though not completely, independent of other people. Finally, the earlier childhood identities are relatively more simple and do not provide as much distinct individuality compared to the complex and unique identity which is normally achieved during adolescence. The attainment of an independent, adult-like identity is the core adolescent developmental task.

Summary of adolescent development. Adolescence, like all psychosocial developmental periods, involves characteristic tasks which consist of coping with stresses (developmental crises) and attaining certain goals. These will be first summarized and then later they will be amplified. Adolescence is a stage of very rapid and striking changes in attitudes and behavior. Also, it is a very irregular period with many transient reversals and "side tracks" in its developmental progression. The "jump" from childhood to adulthood is a very difficult and anxiety laden transition. The adolescent must give up his safe and familiar roles as a child and face a very unfamiliar and unknown future as an adult.

Thus, on the one hand the adolescent must 1) detach himself from his dependent childlike relationship with his parents, as well as 2) relinquish his school-age childhood identity and many of his valuable school-age psychosocial attainments. However, the adolescent attempts to cast off his childhood before being able to attain 3) adult-like identity and roles. The adolescent is left with many "psychological voids", and at the same time i [illegible] ed recourse to his familiar childhood ways of compensating for the voids. The striking physical, especially sexual, maturation which is usually going on at this time simply compounds the difficulties. These factors in early adolescence often lead to a 4) transient psychological disorganization and confusion. This consists of the adolescent being in a state of "emotional turmoil". He will intermittently be intellectually confused and emotionally out of control.

The above psychosocial "dislocations" from a dependent childhood position and psychosocial "shake-ups" arouse many conflicts and much anxiety. The adolescent is faced with a very stressful developmental crisis which he attempts to cope with in various ways. He often attempts to "find himself" and compensate for his identity void and partial emotional loss of parents by 5) attachment to peer groups. The adolescent will shift his allegiances from the parents to clannish peer groups, contemporary teen-age idols, and other adults outside the family who become surrogate parental figures. Another coping device involves the adolescent becoming 6) self-centered, emotionally withdrawing from all people and becoming very preoccupied with himself. Finally, the adolescent tends to intermittently undergo 7) regressions back to a dependent, emotional involvement with his parents.

Eventually the adolescent normally "finds himself", "reorganizes his personality" and attains a solid, independent, and adult-like identity and roles. He then can give up his teen-age fads and may re-acquire many valuable school age-like traits. Eventually he can re-attach himself emotionally to his parents in a new way, e.g., with realistic and appropriately balanced independence and dependence. Finally, at this time he can move on to find intimate, lasting relationships with peers, especially ones of the opposite sex.

More detailed considerations of adolescent psychosocial development.

1. Detachment from parents. This involves the adolescent emotionally and, to some degree, physically separating himself from his parents as compared to when he was a school-age child. The adolescent renounces his child-like reliance on his parents, attempting to be more independent and minimizing the importance of the parents. This normally involves some degree of heightened opposition to the parents' limits and control; a rejection of the parents' dependency offerings; and a rejection of the parents as the best models for the adolescent to

follow. This oppositionalism is nothing new, being especially prominent in most children at the toddler stage when the child is struggling to assert his autonomy. Opposition in the form of passive resistance is also frequently present in the immediately preceding industry stage. However, in adolescence this oppositionalism often reaches a peak of intensity and may take on the form of a generalized rebellion against all authority. Furthermore, the rejection of the parents' dependency supplies, such as offers of help or protection, is also reminiscent of the toddler stage of autonomy. It is also similar in that this rejection vacillates with demands for intensified dependency supplies. However, in adolescence there may be transient rejection of all shows of parental interest and concern, and even appropriate praise is at times unwanted. Finally, the depreciation and criticism of the parents' moral, philosophical, and value systems is something new in psychosocial development. Both of the last two types of rejections of parents are a fairly striking change from the immediately preceding school-age period when parents' interest, help, guidance, etc., where very much desired and appreciated. However, the adolescent at times may insist upon his complete independence and freedom of decision and action. In some cases there is open, direct defiance and rebellion. However, frequently the battles of independence will be fought over small matters with the rebellion being much more covert and indirect. Sometimes the adolescent appears to be completely conforming to the parental wishes when he is at home, but will assert his independence and rejection of their ways in activities outside the home. A small percentage of adolescents may generalize their opposition and rejection of their parents to include most, or all, adult standards and authority. This rejection of the parents' ways is in part contributed to by the adolescents' intellectual developmental attainments. Thus, there is a heightened capacity to abstract, as well as an ability to use deductive and inductive logic compared to the school-age period. Adolescents are able to detach parental contradictions and irrationalities and to see through parental facades which they previously had been fooled by.

Some further examples of the above detachment and rejection of parents are as follows: a) resistance to the parents' limits, rules; especially those pertaining to the adolescent's personal, individual behavior. Thus, the adolescent will oppose parental wishes in regards to clothes, hours he'll keep, type of hairdo or haircut he'll have, and when he'll take a bath. The school-age child on the other hand was more passively resistant usually in other areas that had to do with work activities, especially doing chores and doing his school work. b) Rejection of parents' dependency offerings, such as complaints that the parents treat the adolescent like a baby and won't realize how mature and capable he is to look out for himself; complaints that the parents won't and don't want to let him grow up, and that they overprotect him; complaints that the parents are too concerned and worry about him too much. c) Rejection of parents themselves, such as not wanting to be with or do things with the parents' ignoring or belittling parental advice or suggestions; questioning or even hostilely attacking the parents' ideas about religion, politics, etc.; accusing the parents of being old-fashioned and unable to understand the modern world; complaints that the parents are hypocritical and that their lives are meaningless and convention bound by ridiculous traditions. Parents can be frequently heard to complain that their child no longer seems to respect or even like them anymore.

2. Relinquishment of school-age identity and attainments. This is a kind of self-detachment. There is, as it were, a rejection of the child-like aspects "dislocation" from the childhood position. Previous childhood identities had been given up, but these were always rather quickly replaced by another childhood identity. Here it is different. A school-age identity is more emphatically renounced than at any other time in childhood and no other identity is assumed to replace that which is given up. Also, for the first time a change from one psychosocial stage to another normally involves transient relinquishment of many of the positive attainments of the previous stage. It is as if the adolescent is so desirous of throwing off his childhood, that he throws out "the baby with the bath". The adolescent not only gives up his school-age identity, but also transiently loses or relinquishes many of the very worthwhile psychosocial attainments of the previous school-age period. One of the most prominent transient school-age losses which often occurs involves a loss of "reality contact". Thus, the adolescent has a tendency to lose concern, interest, and involvement with the here-and-now, concrete reality which was such a prominent part of his previous school-age behavior. Another related loss involves a decreased motivation for present reality achievements and constructive activities which the society values.

Some further examples of the school-age rejections:

a) Loss of reality contact, which may include the loss of previous common sense and down-to-earth attitudes; loss of previous practicality; loss of reasonableness of the school-age period when the child could understand and take into consideration reality factors when these were presented to him.

b) Loss of socially valued achievement motivations, such as loss of interest in hobbies; sense of fair play, conscientiousness and reliability; punctuality, neatness and cleanliness; good work, study and hygiene habits; interest in school academic performance including a diminished desire to make good grades (with the grades often falling in the 7th and 8th grades compared to the 5th and 6th grade work); a desire to get up in the morning, tending to want to sleep late in contrast to the school-age child's fairly prompt, spontaneous and appropriate arising. These losses of industry stage attainments are often only relative in relation to changes from the school-age period.

3. Attainment of adult like identity and roles. This task includes struggles fitting into adult-like social and sexual roles. Typically in early adolescence there is an upsurge of sexual impulses, which at times has been described as coming on in waves. Experimentation with sexual roles is typical of early adolescence, and various types of sexual expressions can be observed. Typically heterosexual interests are at first expressed in a playful manner and largely on the fantasy level. The adolescent typically is very anxious about these sexual interests and experimentations and initially will mingle with the opposite sex only in groups of boys and girls, utilizing the principle of "safety in numbers". Later as the adolescent attains more control and comfort around his sexual feelings he will become more open and direct in his heterosexual activity. In late adolescence the struggle becomes more focused on commitments to social roles, including a future, career, marriage, and family roles.

Some further examples of struggles to attain adult-like identity and roles.

a) Multi-directional ("polymorphous perverse") sexual role experimentation and sexual expressions, such as masturbation, sex play with the peers of the same and opposite sex, boys dressing up in women's clothing, and sex play with animals. Also, frequently there will be experimentation with homosexual roles which may be fairly intense and prolonged through most of adolescence. Girls homosexual experimentation may be more overt than boys, and include open admission of masculine interests.

b) Development of the heterosexual role is often an erratic, vacillating process with the adolescent expressing many mixed feelings. These activities often start with such things as parlor games, like "spin the bottle", along with fantasied secret cruches on peers or teachers of the opposite sex. Adolescents will frequently make up many tall tales about their, or other people's, sexual activity, and will indulge in a great deal of gossip about sexual matters. Girls often will write lurid and detailed descriptions of their supposed sexual activity in their diaries, which may come as a great shock to parents who happen to read these. After the group activity and fantasy stage, adolescents typically move on to double dating and finally single dating.

c) There is typically a great deal of interest as well as apprehension around their physical, especially sexual, maturation. Girls often are simultaneously ashamed of and proud of their breast development. Menstruation also typically has mixed feelings associated with it, being on the one hand a "curse", and on the other hand being a pleasureable realization of their femininity. Typically boys are more concerned about slow maturation and girls more upset about early pubertal changes. Also boys are frequently very concerned about the transient breast enlargement which normally occurs in early adolescence, as this is interpreted as a defect in their masculinity and heightens concerns about their being feminine or "queer".

4. Transient psychological confusion and disorganization. A mild confusion and personality disorganization normally occurs sometime in early adolescence, often in close association with the most striking pubertal changes and most intense sexual feelings. However, the main cause seems to be the loss of school-age identity and other constructive psychological attainments with no other identity to fill the void, or acceptable parental support or guidance to help him. There is a loss of control and stability of the personality occurring at a time when increased stabilizing influences are needed to deal with the many other adolescent changes that are going on. External situations, such as marked changes in family relations and separations from home may precipitate and intensify the psychological disorganization and confusion.

This psychological "shake-up" involves the adolescent losing a sense of familiarity with his own inner psychological world as well as his external environment. This is both an anxiety provoking as well as exciting state. Frequently the adolescent will feel exhilarated in a sense of having new, strange, and exciting worlds opening up for him. On the other hand, the loss of a sense of familiarity is disturbing and the adolescent doesn't seem to understand himself, let alone anyone else. Also, his loss of self-control is disturbing since the adolescent cannot trust his own impulses. The adolescent's behavior at this time may become unpredictable to himself, as well as to other people. He may have very upsetting brief subjective experiences of derealization and depersonalization. Depersonalization is an intense and eerie experience that one's body or mind is strange and changed, and doesn't belong to one's self. Derealization is a feeling that the external world is peculiar, "weird", and unreal. Besides an identity void, the psychological disorganization and confusion is contributed to by the adolescent's increased intellectual capacity to abstract and understand subtleties which at least transiently outstrip his capacity to systematically organize his new-found concepts. Thus, there is a tendency for over abstraction leading to confusion.

Some further examples of personality disorganization and identity confusion:

2) Expansion of awareness, and contradictions and vacillations in behavior. This may include periods of intense self-questioning and introspection; intermittently becoming ecstatic about nature, attributing familiar natural phenomena with new and symbolic meanings; spurts of intense interest in political, social or philosophical matters, which may be transient or shifting in viewpoint. Other examples include rapid, erratic vacillations between extremes; such as, from conforming to being very oppositional, from being warm and affectionate to irritable and hostile, happy to

sad; concerned to disinterested and bored. These swings will frequently occur without any apparent or sufficient reason. Also, there often is a marked discrepancy between what the adolescent says and what he does. He may make terrible threats, or sincere promises, or grandiose plans, etc., which are never carried out in action.

b) Disorganized and poorly controlled behavior. This may include periods of undirected restlessness or total apathy and lethargy; marked impatience, behaving as if a slight delay were a major tragedy; impulsively rushing into things without thinking of the consequences, carried away by a whim of the moment; being awkward, uncertain, and often inappropriate when expressing ideas and feelings; being awkward and unmodulated when doing things in general; talking or singing too loudly, or mumbling.

Though the above confused, vacillating and disorganized behavior may persist for many years during adolescence, it typically is at its peak in the first few years of early adolescence. In the rare case, in a predisposed individual, this disorganization will progress and the adolescent turmoil will turn into a schizophrenic decompensation. Also, a small percentage of adolescents will experience this personality disorganization in late adolescence, especially around the time of leaving home, such as going to college. A complete loss of familiar surroundings and identity props may precipitate a rather severe confusional state and be associated with frank delusions and even hallucinations. Such cases are designated "acute confusional psychoses" of adolescence. The prognosis in this latter type of psychosis is much better than in schizophrenia, and often has a complete remission without further psychotic episodes.

5. Attachment to peer groups. It may seem somewhat paradoxical that as part of the adolescent's attempt to find an individual identity for himself, he transiently appears to give up all of his individuality in a rigid adherence to teenage norms and fads. Adolescents frequently demonstrate a marked intolerance of any deviations in themselves or other adolescents from these norms. However, a stable identity takes precedence over a distinct identity, and teenage norms and standards may be desperately needed by the adolescent to provide the stability. Rigid, slavish adherence to temporary teenage standards at least provides the adolescent with a sense of being something definite and predictable. Also, the fact that this teenage identity is the same as many other teenagers is much less important than the fact that it is an identity distinct from "children". i.e., school-age children, and also is distinct from what the parents are and are trying to encourage the child to be. Allegiance to certain peer groups and teenage "culture" in general helps compensate for the loss of the school-age identity and also the detachment from parents. Moreover, belonging to certain restricted cliques and in-groups may provide some sense of individuality

as compared to the general teenage culture. Sometimes the adolescent will switch from one clique or in-group to another, attempting to explore how different groups fit with him and can be used in his search for individual identity. Also, parents may complain that their adolescent is too easily influenced by a peer group. Finally, sometimes the adolescent will take on the identity of a current teenage hero, a peer, or sometimes an adult outside the family. These identities are superficial and transient, having an "as if" quality.

6. Self-centeredness. The adolescent is frequently very wrapped up in himself and his own problems and is generally self-oriented. This takes various forms, such as being selfish, tactless and thoughtless of other people's feelings. It may include periods of global social isolation and withdrawing into himself with daydreams and self-preoccupation. This self-centeredness may alternate with periods in which the adolescent becomes extremely involved and intimate with other people. Frequently, however, when he appears to be the most outgoing and communicative, the self-centered orientation may show itself by a lack of true reciprocity and empathy with other people. Another facet of the self-orientation may be overconcern with bodily sensations and hypochondriasis.

7. Regressions to a dependent, child-like position. These reversions to a childish dependency are not literal returns to an earlier type of dependency on parents. The adolescent's ambivalences and identity struggles and confusions are evident in these intermittent retreats into dependency. There are several causes for this regression. Thus, the adolescent on some level recognizes that in many ways he is still a child and needs his parents help and care. Also, the adolescent typically continues to have truly positive and warm feeling for his parents despite his negative feeling and emotional detachment, i.e., he is ambivalent about his parents. The adolescent's identity confusion and personality disorganization also make him more in need of external guidance. On some level he may recognize that the peer group attachments at times involve insufficient, unproductive, and self-destructive guidance. Finally, the adolescent often becomes anxious and also guilty about the negative, hostile feeling towards his parents which are a part of his emotional detachment from them. Over-all, the adolescent intermittently becomes frightened of his detachment and periodically returns to the parents offering them love and asking for dependency supplies.

However, a return to a dependent relationship with parents itself is an anxiety provoking situation. The adolescent often feels ashamed of himself. In order to save and maintain self-respect he may shift the blame to his parents for his behaving in a childish way. The adolescent may resent his parents acquiescing and supplying the very dependency gratifications which he requests.

On the other hand, if the adolescent's dependent retreats aren't accepted and complied with, then he also may become anxious as well as furious at the parents for depriving him. Thus, the parents are often "damned if they do and damned if they don't" in this area. The adolescent may ask advice from parents, and then turn around and become angry at the content or the manner in which the advice was given and say that the parents are treating him like a child, and he ignores their suggestions. However, after the advice proves to be correct the adolescent may again become angry at the parents for not forcing him to accept their advice. At times the adolescent's requests for dependency gratifications may be on a very immature, childish level--such as wanting special candy or food, and wanting the parents to read his mind and get him something he wants without his asking for it.

Final Statement

The above descriptions of adolescent development have covered many of the commonly encountered problems and coping mechanisms. However, this was not meant to be an all inclusive summary of adolescent behavior. Also, I did not mean to imply every adolescent shows all, or even most, of the behavior I have described. For example, some adolescents never extensively involve themselves with teenage peer in-groups. Also, they may show adaptive mechanisms not mentioned so far, such as "intellectualism", asceticism, and "altruistic surrender" (a "triad" Anna Freud described in European adolescents). Even though most contemporary American adolescents show some aspects of each of the above major categories, it is also true that variability from one individual to another is the rule.

Furthermore, a given adolescent may clearly show different conflicts and adaptations at different times in a shifting manner. Also, the same adolescent may show a confusing array of bits and pieces of different problems at the same time. The above categories of adolescent development, like the concept of adolescence itself, involve a somewhat arbitrary and artificial but useful way of understanding things. However, in reality things are not so clear cut and compartmentalized. Development does not occur in a smooth manner from one delineated phase, task, or even stage, to another. Variability and overlap within a given individual is the rule.

With patience and some understanding, as well as some limits, from adults, most individuals are able in time to successfully struggle through their adolescence and attain an adult-like psychosocial status. They are then ready to proceed into their adulthood developmental stages. Psychosocial development doesn't stop after adolescence. Erikson has described the first adult stage as one of "Intimacy versus Isolation". And so the post-adolescent moves on into another developmental arena where he attempts to find reciprocal, intimate and lasting relationships with individual peers, especially of the opposite sex. At this point we will arbitrarily say that adolescence ends, just as we arbitrarily said it began when we artificially cut it off from the school-age period.

THE ADOLESCENTS' DILEMMA*

By Kenneth A. Wells

Adolescence starts earlier and lasts longer than it used to. Consciously or unconsciously, the adolescent wants to use this time for activities that will help him achieve for himself the identity, occupational role, emotional independence, mature social-sex role, and stable values that will enable him to enter adulthood. Adults need to understand these developmental tasks, and to allow young people sufficient and relevant opportunities to fulfill them.

ADOLESCENTS ARE, almost from day to day, in a dilemma. They are confronted with the need to choose between relatively unsatisfactory courses of action or behavior. What has happened to the period of adolescence? Of what nature are the developmental tasks of adolescence? What might be some guidelines for the future?

Meaningful consideration of the problems of adolescents must include an attempt to recognize and to relate what has happened to the adolescent period and to the developmental tasks of the period. Change, and the inevitability of change, are about the most common factors in the present experience of mankind. Of perhaps equal significance is the rapidly increasing pace of change, and this too bears heavily on adolescents.

What has happened to adolescence? In this age of rapid social change, it takes twice as long for a boy to get through adolescence as it did in the first couple of decades of this century. If this is a fact, and I believe it is, it is one factor underlying the adolescent's dilemma.

Adolescence is generally defined as the period from puberty to maturity. Puberty is a strictly biological term. Maturity is a social term reflecting rather vaguely the indefinite point at which society accepts the growing individual as an adult or "mature" member, and allows and expects him to fit the adult society's behavioral norms. About two generations ago, this period was considered for most boys to be from about age 13 to 14 to about 18 or 19. Young men were then expected to be rather securely established in society. This was a period of about 5 or 6 years. Today, this period is considered to be from about age 12 or 13 to about 22 or 23. This is about 10 to 12 years. For boys, it is twice as long as formerly; for girls, the period has also been extended but not quite as much.

---

*Reprinted from Texas Medicine, Vol. 65, pp. 60-65, 1969.

Another way to describe this is to visualize the life experience from birth to mature adulthood as a cone. Not only does it have a dimension of length - the passage of time - but it also expands as the total perspective of the individual increases in scope. Adolescence is a slice of this cone of experience. It is not only a thicker slice than it used to be in relation to the length of the cone, but it is expanding in diameter as well. I suspect that this "two-way stretch" will continue. Our task is to learn how to accommodate to what has developed.

Some of the factors which raise the age of late adolescence are extended education, military service, job preparation, and an economic system of specialization. The factors that lower the age at which adolescence begins are both biological and cultural.

The upward extension is the more significant. In 1900, only 11% or all 14-17 yearolds were in any kind of school, and a high school diploma was a rarity. Today well over 80% of them are in school.

In 1900, only 4% of all 18-21 yearolds were in college. Most of them were preparing for the professions; almost none of them were women. Today, over a third of the people in this age are in college and a high school education is an almost universal goal. A college degree is more common today than a high school diploma 60 years ago. Thus the period of education has been greatly lengthened, and at least two years of military service has been superimposed on boys. One may argue that military service helps develop maturity, but in many instances it may actually postpone the process because job preparation and specialization often require additional years of study and training before one is settled. This process of upward extension has not resulted in later marriages. It may even be the cause, in part, of earlier marriages. As young people strive for full adult status they can get married, and this provides one clear and specific symbol of maturity.

The factors making the downward stretch are both biological and cultural. Biologically, boys and girls haven't changed much but they have changed some. They tend to be taller and generally healthier, and they reach puberty from 9-12 months earlier than they did in 1900.

We often hear that children today are much smarter than they used to be. It is doubtful that they are "more intelligent," but they are more sophisticated because they have been exposed to a greater variety of ideas and experiences. For many of our children, the affluence of society has led to new opportunities for experiences, and at younger ages. The revolution in transportation has expanded horizons and expectations of many youngsters today. I graduated from college without having traveled beyond my home state and the one across the river, but at that time travel of any extent was not an expectation of most families. The revolution in communications through radio and especially television has greatly expanded the area for vicarious experiences and thus increased the body of accumulated information known to youth. Increasing affluence has enabled parents to give their children some of the kinds of experiences that they did not have, or that they could only expect to experience at older ages. Parents frantically seek to give their children "advantages." In one sense it is probably a part of the parents' own quest for status.

None of these changes are bad in and of themselves. They do help to account for the earlier sophistication of youth. Mary knows the binary system and Johnny understands rocket engines, but this is not evidence that they are more ready than their parents were to enter into the adult society.

Thus, the factors of biological change, of affluence, and the increased requirements of education and job preparation have combined to extend greatly the span of adolescence. This trend is not likely to be halted, let alone reversed. Our task is to understand it and find ways to cope with the consequences.

These factors affect the average youth in our country. I know the danger of averages and I am fully aware that quite different critical problems face our youth in the inner city, and among low-income and minority groups. Their problems are exacerbated by their inability, for many reasons frequently beyond their control, to keep pace with the mainstream trends of the culture. They may be forced to drop out but they can not and will not simply stand aside and watch. This problem is beyond the scope of this article, but it demands specific remedial action.

What is the nature of the developmental tasks? Some of the adolescent's serious problems arise because this period of his life has been greatly lengthened and much of what occupies the time is not sharply or clearly related to his basic developmental tasks. Our adult concern for youth has its paradoxical side: We have extended childhood, relieved youth of adult responsibilities, and then frantically tried to create ersatz tasks that look like responsibilities. We refer to adolescents as "young citizens," but there is an artificiality about it all that both we and they know to exist.

Adolescents are, as the old saying goes, neither fish, fowl, nor good red herring. On the one hand we say, "Why don't you grow up and act your age?" In the next breath we are just as likely to say, "You can't do that - you're not old enough." The adolescent is keenly aware that he is no longer a child - he has to reject the sure safety of this position yet, on the other hand, he is not accepted as an adult. He falls between two stools and the distance between them becomes greater. For him, this world may be exciting and thrilling one day and discouraging and terribly boring the next. He runs forward to test the limits and boundaries of society at one moment and draws back to safety and security the next.

Fritz Redl has said, "If you are too old to suck your thumb, and too young to take a drink, what else is there to do?"

If adolescence, as I have defined it, is much longer than before, then let us examine its basic developmental tasks.

Dr. Robert Havighurst and his associates provided the first clear statement of the developmental task concept. A developmental task is a task which arises at or about a certain period in the life of the individual, the successful achievement of which leads to his happiness and to success with later tasks, whereas failure leads to unhappiness in the individual, disapproval by society, and difficulty with later tasks.

The basic tasks that each boy and girl must accomplish while growing from childhood to maturity are:

1. The achievement of a self identity.
2. The achievement of an adult occupational role.
3. The achievement of an emotional independence from the family.
4. The achievement of a mature social-sex role.
5. The achievement of a stable scale of values.

The achievement of a self identity, or the lack of it, is a problem that physicians meet regularly. Knowing who one is, where one "fits," and testing one's capacities and limitations is a process that commences early in life. Children need as many relatively safe opportunities as possible to test and evaluate themselves with their siblings, peers, and adults. Many adults never fully resolve this task in their lifetimes, but one major task of adolescence is to make progress toward its resolution.

The achievement of an adult occupational role is essential in our society. Being a mother and a housewife is still one acceptable solution for some women, but an increasingly less satisfactory one for many. For men, society demands an occupation and more and more years are devoted to preparing for it. Among the concerns of adolescent boys, this problem ranks second only to their concern with education which is of immediate import and is the prelude to an occupation. As they move through adolescence their occupational aspirations, quite understandably, come closer to reality. For example, 72% of 11-year old boys expect to be professional men, but by age 16, this proportion has declined to 48%. This is still unrealistic for the foreseeable future, but it indicates that the American dream persists and yet shapes toward reality. The important point is that during adolescence, major progress toward resolving this task must be made if social maturity is to be achieved.

Historically, and to some extent even today, the work opportunities for youth partly prepared them for adult occupations and responsibilities. Certainly this was true on the family farm, and in apprenticeship to a craft. Even household tasks used to make more sense because they contributed to provision of the family's food, shelter, and warmth. For most children and youth today, this simply is not true. There are fewer and fewer meaningful and worthwhile tasks in the home. Even those that remain do not lead to a sense of family need or personal worth, and they have almost no connection with the future skills of adulthood. In this respect, girls have an advantage over boys. A boy in today's world has greater difficulty in learning an appropriate masculine role than does a girl in learning an appropriate feminine role. During middle adolescence, more girls than boys earn money from various kinds of employment.

The achievement of emotional independence from the family is essential and frequently more difficult for parents than for children. Parents must relax the ties and children must test them. These are not the ties of love and respect, but the ties of deep and continuing dependency on the part of some children and a reversal of this dependency on the part of some parents. The process cannot be expected to be without explosions and revolts. I am always a little concerned with the youngster who has never revolted in some manner from his family or his family's surrogate institutions such as the church or the Boy Scouts. These institutions have a task to help in this uneven and necessary process of emotional tie breaking.

The achievement of a mature social-sex role is critical. The extension of the cultural aspects of adolescence and of dependency runs directly into the nature of the naked ape as Desmond Morris pictures him. Increasingly, biologically mature males and females cannot and will not curb their sexuality to fit the changing demands of the culture which has postponed the date of acceptable social maturity. Reluctantly, society seems to be accepting patterns of premarital sexual behavior which threaten the shibboleths of older codes. The establishment of the pair bond relationship or of the new family does not wait, but neither is its establishment in our society necessarily an evidence of maturity. Young people can and do marry, and this establishes a visible symbol of what society has traditionally labeled as an aspect of maturity. The other aspects of maturity such as the establishment of self identity and the achievement of an occupational role are likely to lag behind - often to the danger of the marriage itself.

The establishment of a stable scale of values is a task for every adolescent, and in today's world, the guides are not clear because society itself is in the process of reassessing its value structure. Historically, the ultimate values tended to stem from one's religious heritage, but the religious institutions too have been shaken severely by the industrial and scientific revolutions. As a culture, we are divided in many ways over matters of ethics and morals. I do not see any spectacular growth of militant atheism among youth, but rather a vigorous questioning of traditional religious concepts and values - frequently ones that are denied or at least not practiced by the very adult society which sends its youth to the church. It is my personal opinion that a new system based more clearly on the humanistic values of mankind is developing and that it is wholesome. Even if it is good in the long run, this process does little to guide adolescents through the jungle of a society that is far from settling on its own goals.

More and more there is conflict between the traditionally stated values which stem from our common Judeo-Christian tradition and a different and powerful set of values, pounded home day after day by other important segments of our society. Magazines, radio, television, motion pictures, advertising, and other media emphasize other values for other reasons. These values are frequently related to being always young and beautiful, being envied for what we can own and control, being sweet smelling and attractive to the opposite sex, being powerful, admired, successful. While ostensibly we profess allegiance to the values of our ancient religious traditions, in real life the stress is on the aggressive, the successful, and the individualistic. Values are changing constantly and social problems always can be expected to grow where there is a sharp difference between the sanctioned means and those that are readily acceptable in day-to-day living.

Progress toward the resolution of the developmental tasks is neither direct nor steady and the intermediate steps can not be neatly charted. Adolescents themselves are not consciously aware of the need to accomplish these tasks, nor need they be. On the other hand the tasks cannot be ignored by those of us who presume to work with adolescents or to treat their ailments or alienations, for failure to make progress during adolescence leads to unhappiness in the individual, disapproval by society, and difficulty with later tasks.

Guidelines for the Future: I have no ready-made prescription, but I believe that some things can be done by the society and its institutions that will help us to accommodate to the situation we have inadvertently and rather suddenly created. Perhaps the adolescent's dilemma can be ameliorated.

Fundamentally, we must create various meaningful relationships between adolescents and adults. This depends partly upon the way we adults relate to our own society, and partly upon our ability as adults to create "linking mechanisms" with adolescents and their subcultures.

Adolescents must be able to see the adult society as one worth joining because its goals and their goals have enough in common to make this possible. Although our society has changed dramatically in the past generation, many adolescents and young adults sense a falseness and hypocrisy in the process. In their view, we have enthroned statistical affluence as a goal and now are belatedly concerned with its meaning for a large segment of our society - the low-income and minority groups.

We have, in some respects, created a shell game for all to see: We can demonstrate massive grief for Martin Luther King, Jr., on the one hand and refuse to accept the principle of open occupancy for our neighborhood on the other. We can garner tremendous effort and talent to save a single life or conquer a virus and at the same time build a national arsenal capable of incalculable destruction. We can save the whooping crane and lose Lake Erie at one and the same time. The adolescent needs to see a society, no matter how great its troubles and its responsibilities, that knows its priorities and moves however hesitatingly toward its goals. I am afraid that he does not see our house as being in order. He needs to see individuals who can articulate their deepest convictions and then live by them without tortuous rationalizations.

We have, over the generations, created institutions, agencies, and organizations to deal with what society has always seen as the "problems of adolescence." They are needed as "linking mechanisms" to help bridge the gap between adolescence and adulthood, and they include the church, the school, and the many so-called youth serving agencies, some which are geared to doing more for than with children and youth.

This leads to an important need: The need to devise ways in which, throughout adolescence, youth can increasingly share meaningful decision-making about matters related to their lives, their families, their churches, and their communities. Many organizations allow this opportunity to a limited extent, but in general we adults reserve the important information and big decisions for ourselves.

Could we create meaningful opportunities for adolescents to contribute to the total society? The Peace Corps is our best present example, but its participants are somewhat older. Similar domestic opportunities could be created, through private channels, for 15-16 year-olds.

Could our organizations and institutions change more rapidly in order to give our programs the "today tempo" to match the needs of the adolescents of today and tomorrow? I suspect that above all this would call for a new flexibility on the part of adults still accustomed to patterns handed down from long-dead founders who created organizations and agencies to deal with a very different set of problems.

Could we create programs that provided real opportunities for important job exploration? Explorations that could move out from the classroom and the textbook into real life would help to fill one of the real voids in the adolescent period. This would require the creation of adultlike activities and programs, and it will demand volunteer time and effort from men and women willing to learn the nature of the adult role vis-a-vis adolescents. Adolescents do not reject adult leadership and counsel; they want it. But most adults do not understand how this role changes, for example, as seen by an adolescent of 14 and by one of 16 or 17. I suspect that we focus too much attention of providing "fun," and forget that in their own inchoate way, adolescents are trying to focus upon decision-making for their own lives extending through and beyond high school and college. There are mature satisfactions to be had at this age as well as fun to be enjoyed.

Can we make more use of our existing organizations and agencies as relatively safe testing grounds for adolescents? In many respects, adolescents comprise a distinct subculture, just as do the adults of the ghettoes. And the adolescents in the ghettoes are our most alienated people today; many of them have quite simply rejected us as hopeless.

Organizations that are too cautious to take risks or allow their members to take risks lose their members. They hesitate for fear of losing their supporting adult structure. In some respects they have built untarnished, and perhaps unreal, images of accomplishment. If organizations are effective in linking adolescents to the adult society, they must change some of their goals and expectations.

Conclusion: Adolescence has been greatly extended. The satisfactions of adult society have been pushed farther into the future for the adolescent who at the same time is exposed to more new and tempting experiences paraded before him by an affluent society. Full of energy, drive, and curiosity, he is sidelined with virtually nothing to do except go to school and have fun. What he is forbidden, he samples surreptitiously. How can we expect him to prepare for the adult world if he is denied the learning that comes from meaningful participation? This social segregation of adolescents in a largely "fun" world may have played its part in the frantic efforts of many to drop out and freak out.

If we understand the nature of the developmental tasks, and if we as adults master our roles in relation to adolescents and their tasks, then we have a chance to develop new attitudes for ourselves and to create linking mechanisms that can at least help to resolve the adolescents' dilemma. Society's dilemma will deepen if we fail.

Mr. Wells, Director of Research, Boy Scouts of America, New Brunswick, N.J. 08903.

This article reprinted with the permission and through the courtesy of Mr. Wells and the Texas Medical Association.

INSIDE WHAT'S HAPPENING: SOCIOLOGICAL, PSYCHOLOGICAL, AND SPIRITUAL PERSPECTIVES ON THE CONTEMPORARY DRUG SCENE*

By Allan Y. Cohen, Ph.D.

The abuse of psycho-active drugs by young people is a frustrating public health problem. The so-called "psychedelic revolution" of the 1960's has created an increasingly large population of teenagers ingesting various mind-altering substances. At the same time, efforts at prevention and discontinuance of drug abuse have been relatively ineffectual, partially because of the recency and prevalence of drug abuse, but primarily because techniques of drug control and drug education are only beginning to respond to the motives underlying the rapid rise of the "turned-on" generation.

In the present paper, let us focus on the psychedelic or hallucinogenic drug phenomenon. Cannabis products, viz. marijuana and hashish, are included in this discussion because of recent developments isolating THC as a primary active ingredient in cannabis derivatives.[1] Preliminay research,[2] as well as clinical observation by the author and other psychotherapists, suggests the action of THC as subjectively equivalent to materials such as LSD, psilocybin, mescaline, DMT, STP, and other. (It is suggested that contemporary marijuana use can be seen as relatively low dosages of potent hallucinogen.)

The observations below represent a synthesis of findings derived from research and counseling with young users of marijuana and psychedelic drugs (many of whom had also tried amphetamines, a few of whom had experimented with barbiturates and herion). Observational data were provided by hundreds of hours spent by the author in counseling undergraduates at the Counseling Center, University of California, Berkeley. Additional information was obtained in informal conversations with high school and college students all over America in conjunction with drug education lectures given by the author. Empirical and systematic data are taken from investigational research done for the Bureau of Drug Abuse Control.[3] This study included a survey of drug attitudes and use among psychedelic users in the Haight-Ashbury section of San Francisco and Telegraph Avenue section of Berkeley. Also included was an in-depth interview study of 14 high school users and exusers, an empirical investigation of value changes in 40 LSD users, and an anthropological analysis of the rise and fall of the drug scene in youth subcultures in Chapel Hill, N. C., and Fresno, Calif.

---

*Reprinted from American Journal of Public Health, Vol. 59, No. 11.

[1] Collier, H. O. J. The Essence of Pot. The New Scientist (Aug. 13), 1967.

[2] Isbell, Harris, et al. Effects of (-)-9 Trans-Tetrahydro-Cannabinol in Man. Psycho-pharmacologia 11,2:184-188, 1967 (reprinted in Mental Health Digest, NEW-NIMH publ. (Dec.), 1967).

Motivations: Sociocultural Considerations

There is no need to dwell on the expectable motives operating in drug abuse. Curiosity, social pressure, rebellion against authority, escape from social and emotional problems, desire for "kicks"--all these are more or less relevant in many cases but add little to our capacity to understand the recency and magnitude of contemporary drug abuse. Beyond these obvious aspects are cultural and psychological factors that come to the attention of the listening ear again and again, exquisitely articulated by some college students and teenagers, subconsciously expressed by those in their pre-teens.

The theme is one of disenchantment and alienation, particularly in the area of values. Increasing numbers of young people have been struck with a sense of futility regarding the basic institutions of their society. They charge social and political hypocrisy, and reject governmental and social policies that seem headed toward more war, hate, and injustice. They have begun to challenge the very goals of the educational system which trains them for jobs incapable of guaranteeing personal satisfaction. They criticize parents, citing their basic lack of understanding and discrimination toward what is really important. They are put off by organized religion--symbolized by rite, ritual, ceremony and dogma--that seems to deny inherent human worth, and to exist for hypocritical adults who attend church without seeming to be touched with love for God or their fellowmen.

Reflecting such attitudes, the psychedelic scene is a middle- and upper-middle socioeconomic class phenomemon. It operates from material sufficiency, not economic deprivation. Pot and "acid" are not functional to the ghetto individual and the poverty-stricken minority member. Their drugs of choice are alcohol, barbiturates, heroin, and other depressants or "consciousness-contractors." The use of psychedelics has not flourished among the economically underprivileged, perhaps because they need to *forget what already is*. Children from affluent families can suffer a different kind of pain--a need *to find that which they do not have*. Here we re-enter the area of the search for meaningful values.

---

[3] Cohen, Allan Y. Educational Strategies Related to Psychological and Social Dynamics of Hallucinogenic Drug Abuse. Unpublished research report submitted to the Bureau of Drug Abuse Control (Dept. of Justice, Contract 67-25), June, 1968.

Motivation: Psychological Considerations

Time and again, one hears teenagers asking the questions phrased according to their age and verbal skills, "Who am I?" and "What am I doing here?" Some social scientists have called this the search for identity or meaning. More and more young people (freed from considerations of economic survival) find it hard to accept the basic value system that modern civilization has emphasized--materialism and the quest for affluence and material achievement. Less and less are young people satisfied with a system which seems to push them toward greater education designed to help them attain more prestige jobs leading to high income and social status. To many teenagers, it makes no sense, especially because it has not led to widespread personal satisfaction and happiness in the adults most visible to them. This rejection of values associated with material acquisition has led to confusion, a vacuum in meaningful goals, and a search for something "inside."

An initially apparent alternative is the use of drugs. After all, our culture and communications media teach children that one solves almost all problems by "turning on"--drugs for headaches, constipation, sleeplessness, "nerves," and for whatever other maladies beset us. Taking drugs is the common palliative in our society, not a deviant one. Thus, it is difficult to fashion public health approaches without realizing the cultural logic and appeal of mind-altering drugs, although their illicitness and uniqueness would seem to set them apart from the mainstream of justifiable drug use.

Motivation: Spiritual Considerations

Many adults are puzzled at the preoccupation of young drug experimenters with issues connected with "consciousness" and spiritual development. There is an intense and growing interest in writers and ideas about inner experience--from "sensitivity" groups to meditation and mysticism. Ironically, much psychedelic drug use is oriented toward attaining these higher states of awareness. Psychedelic religions have been created; getting high seems sacred to large groups of young people; physiological, legal, and psychological side effects seem irrelevant to them--e.g., "I don't care about chromosome damage or getting busted or going crazy if I can get enlightened, find God, and have real peace inside myself." Consequently, drug use connected with consciousness-expansion is particularly tenacious because the information about more mundane dangers generates little credibility and even less concern.

The situation is ironic because valid techniques for attaining spiritual experience or higher consciousness are directly contradictory to chemically induced mind alteration. In a surprising number of cases (especially in the age range of 15 to 22), individual users have discontinued their use when they discovered that respected spiritual leaders and mystics regarded the use of drugs as useless and harmful in one's spiritual development. Particularly influential in our San Francisco and Chapel Hill samples were the statements of Avatar Meher Baba, a spiritual master who lived in India, considered by his followers to be God in human form.[4] Responding to letters from one of the foremost psychedelic leaders in America, Baba wrote that "The (drug) experience is as far removed from Reality as is a mirage from water. No matter how much one pursues the mirage one will never reach water and the search for God through drugs must end in disillusionment."[4,p.2] The dynamics involved for the users who gave up drugs because of such statements are instructive in fashioning public health programs directed toward the sincere but naive "seeker" experimenting with drugs.

PUBLIC HEALTH INTERVENTION STRATEGIES

Certain conclusions and recommendations flow from the systematic research and field observation. Most noninnovative approaches have failed to touch the psychedelic subculture. The possibility of legal action is an annoyance to the drug user, not a deterrent. The "scare" approach is not only ineffective, but undermines the credibility of the concerned professional when he attempts to communicate objective facts. Obviously an educational approach is the most reasonable answer to the drug abuse problem but drug education has lagged behind the sophistication and rationalizing power of the casual and chronic drug abuser. After assessing factors responsible for the discontinuance of psychedelic use, certain principles seem basic to producing behavior change:

1. An empathic, sympathetic attitude toward drug users,
2. Reorientation of legalistic to public health approaches,
3. Therapeutic stress on motives behind drug use, not on drug use itself,
4. Availability of objective information on drugs,
5. Establishment of credibility for drug education communicators,
6. Emphasis on utilizing ex-drug users as communicators,
7. Assignment of greater responsibility to young people in political and social policy planning, and
8. Inclusion of young users or exusers as consultants in any drug intervention programs.

---

[4] Baba, Meher. God in a Pill? Sufism Reoriented. San Francisco, 1966.

However, perhaps the most understressed objective in any public health campaign is the provision of alternatives. In a sense, we have been hampered by taking a defensive posture, trying to eradicate drug abuse without providing for those opportunities which could reduce the desire for drugs. Of course, if we could cure the ills of our society, stop the disintegration of the family unit, and make life more meaningful for young people, the psychedelic drug scene would disappear. This is a long-range objective. More practically, it might be extremely wise to reorient our public health approach in the home, school, and community so that we put special priority on developing and implementing nonchemical alternatives to the search for meaningful inter-personal relationships, enduring values, and inner experience. Some of the practical possibilities of providing such alternatives appear elsewhere;[5] here it may suffice to note that whenever attention is redirected to this kind of orientation, viable prospects begin to pop into view. Whether it involves broad curriculum changes, opportunities for political and social involvement, study in practical mysticism, growth-oriented individual and group counseling or whatever, the fact is that young people will cease using drugs if they are provided with some better nonchemical technique. The hidden ally here is the ultimate failure of drugs to fulfill the real needs of the users. If drugs did work, we might as well scrap any countermeasure. But chemicals are not effective; more and more young people are finding this out, though occasionally too late.

If alternatives are initiated in the earlier grade levels, we shall have gone a long way in the prevention of drug abuse. Casual experimentation provoked by curiosity may still continue, but habituation will be unappealing and even unfashionable. It is not very difficult for the user of cannabis or LSD to stop if he wants to stop. The critical issue is to get him to want to stop; this comes automatically when he finds a meaningful nonchemical alternative.

Sociological and psychological investigations lead to the final conclusion that drug use is only a symptom of the disease of our times. That reality may seem frustrating to those concerned with drug abuse; yet it is equally challenging. For if we start approaching drug misuse by supplementing effective public health education with the provision of viable alternatives, we begin to act on the very causes of human unhappiness. We start to actualize a type of context enabling young people to explore their inner potentialities within the social fabric. In addition to reducing the self-destruction of the drug path, we may be facilitating mental health in a stressful society. The most that can be lost in the attempt is ignorance.

---

[5] Cohen, Allan Y. Psychedelic Drugs and the Student: Educational Strategies. Journal of College Student Personnel 10,2:96-101, 1969. Marin, Peter, and Cohen, Allan Y. A Parent's Guide to Drugs. New York: Harper and Row (in press).

Dr. Cohen is Assistant Professor of Psychology, John F. Kennedy University, Martinez, Calif. 94553.

This paper was presented before a Joint Session of the Averican School Health Association and the School Health Section of the American Public Health Association at the Ninety-sixth Annual Meeting in Detroit, Mich., November 12, 1968.

INFORMATION AND MISINFORMATION ABOUT DRUGS*

By Sidney Cohen, M. D.

How do people find out about mind-altering drugs? What is the quality of the information? How are their attitudes formed? What enhances or deters drug-taking behavior?

The direct person-to-person message has been and remains a potent vehicle for transfer of information. It is especially powerful in the drug area because it carries both the conviction of personal experience and the emotional loading of the transmitter. In a study of drug-taking networks within relatively closed groups, it has been found that drug usage spreads centrifugally by word of mouth especially when the initial source is charismatic or occupies a position of leadership.

But the enormity of the psychedelic experience is such that it is accepted by the credulous without thoughtful evaluation. Identical subjective phenomena are called "mystical union" by one, and "depersonalization and derealization" by another. Visions and insights for one may be hallucinations and delusions for another. Very often the "good trip" is no different from the "bum trip" except that one person relishes loss of control and becomes ecstatic, while another becomes panicky and horrified.

Words are potent shapers of behavior, but nonverbal messages are also powerful. Especially in the young, mimicking activity of valued others is pervasive. Simply being a member of a drug-using subgroup makes the probability of indulgence likely. To ape, to copy, to imitate, these activities are doubtlessly genetic imprints.

At another level of discourse the user turns on the non-user with "it's harmless, I've taken it." This sort of claim returns us to the age of innocence of herbal folk lore and the patent medicine testimonial. The heavy cigarette smoker, the woman who took thalidomide during the seventh week of pregnancy, and the joy popper of heroin all could make similar assertions. If only things were that simple.

---

*Condensed from a paper presented at The Rutgers Symposium on Communication and Drug Abuse, September 3-5, 1969.

The person-to-person interchange is the most important source of information and misinformation. I suspect that the tongue is mightier than the pen in moulding human behavior. This is so because it allows for an exchange, an interaction, and a transfer of emotional as well as verbal messages. Small groups are more effective than large groups, and one-to-one transactions have the greatest impact of all.

The mind-altering drugs themselves are a communicative and sometimes a symbolic message. Their statements may be anything from "Feel better" to "Expand your consciousness." These are beguiling messages, for who does not want the promise of euphoria or Nirvana? But the question remains: Is the pearl of no price a pearl? Is the unearned Paradise worth only what one has paid for it? To me it is astonishing how quickly the insights and the enlightenments fade, and little has changed except the illusion of change.

Another source of information is what may be called the old literature. Drugs like cannabis, opium, and Peyote have been around a long time and a vast literature is available. This collection of materials is highly variable for much of it seems to have been written by biased or poorly trained reporters. The descriptive content is interesting, but the conclusions should be accepted with reservation. We are only now laying the foundation for the scientific study of cannabis.

As one scans the array of tales about drugs, one impression prevails. The strenuous and pervasive efforts of men to alter their consciousness is hardly new, nor have the reasons for drug usage changed substantially. They want to feel better. They are bored, in pain, frustrated, unable to enjoy, or feel alienated. Some plant carries with it the promise of oblivion, surcease, quietude, togetherness, or euphoria. Modern technology has now added intoxicants, deliriants, ataractics, confusants, dissociatiants, calmators, and alertors.

We tend to extract from the earlier archives those quotations that fit our prejudice. Thus, the LaGuardia report is used by both sides to demonstrate both the safety and the dangers of marijuana. Similarly, in the ancient ideographs we read that hashish was an enhancer of meditative and of assassinative activity, and can proceed to select that quotation which fits our preformed judgments.

Some latter-day research reports are not lacking in ambiguity, improper design, and drawing of conclusions from insufficient data. It is in the nature of early scientific efforts to produce much that is irrelevant or down-right incorrect. That Kepler turned out to be wrong in many of his theories and calculations does not reduce his importance.

Let me cite two examples of what I consider unwarranted conclusions from our current reseach reports.

There have been dozens of experiments on chromosomal changes in connection with LSD exposure. We are confronted with a stack of articles by capable researchers, some of whom have demonstrated chromosomal structural changes, and others who have not been able to replicate this finding. I do not know what the score would be if we listed the positive and the negative reports, but it may well be a tie.

We are aware that a number of commonly used drugs and other chemicals are capable of chromosome rearrangement. What does all this mean? What should we say at this moment in time regarding the actual cause-effect relationship between LSD and subsequent genetic disorders in the individual or his progeny? Today, the question can only be placed in the "hold basket."

Another example of overinterpretation of results, if not by the authors, then by those who read the article, was a driving simulator test comparing alcohol and marijuana. The dosage level for marijuana was a "normal social high," or two cigarettes of unknown strength. The dosage level for alcohol was a 0.1 mg% blood level. These amounts hardly seem equivalent, yet the article implies that driving under alcohol is more hazardous than driving under marijuana. It would have been much more desirable to derive dose-response curves on these two substances than to extrapolate from unequal dosage levels of marijuana and whiskey.

There is nothing wrong with saying, "We do not know" when we do not know. Nor does "We don't know" mean "It is harmless."

In speaking of research findings and sources of information about drug abuse, I must not fail to mention the availability of annotated bibliographic reference material stored at the National Clearinghouse for Mental Health Information. Other data banks are available for similar services.

Much has been written, broadcast, and televised about drugs and drug abuse. Without question, the public information systems have had an important, perhaps a decisive, effect upon the drug scene. At the turn of the century Weir Mitchell and Havelock Ellis spoke as glowingly of their peyote experiences as Aldous Huxley and Allan Watts did of mescaline and LSD in the early 1960's.

The mix of mass media material has varied from excellent to terrible. By terrible I mean sensational, inaccurate, and misleading. This is natural, because news is that which is new or novel. The need to emphasize the unique, the esoteric, and the strange is inherent in the papers, radio, and TV. Television and radio are especially difficult media for transmitting information that requires thoughtfulness.

Then there are the underground newspapers. Just why they are called "underground" when they are so above ground is difficult to understand. Originally, the latter-day underground press was drug centered, and the information was often enough lacking in accuracy, but sometimes the facts were "straight."

At the point when large numbers of people are misusing alcohol, uppers, downers, psychedelics, and an assortment of other chemicals, we must ask what can be done to reverse this trend. First we must recognize that this is no fad that will yield to next year's equivalent of goldfish swallowing. More dangerous agents seem to be displacing the less dangerous ones. Then we must acknowledge that events outside the drug scene may have a greater impact on the problem than any direct effort.

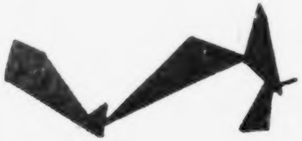
All of us acknowledge the need for more research, more skillful education, and more accurate information on drugs of abuse. Still we cannot expect too much, too soon from research and re-education.

Nor will attempts to legislate drug taking out of existence solve the problem. The modification of human behavior by the threat of legal punitive action is a relatively poor technique of accomplishing the desired end. If the punishment invariably or frequently followed the aversive behavior, it might be successful. When the chances of punishing the lawbreaker for a drug possession violation are probably less than one in a thousand, we can expect little behavior modification. If the sanctions are excessive as in the case of simple possession of marijuana, the ills they engender exceed any benefit.

Does all this mean that nothing can be done to influence the rising incidence of drug abuse? Not at all. What could transform the bedrugged scene relatively rapidly is a viable equivalent for spurious promises that drugs proffer. If people turn to drugs because they feel alone, are hurting physically, or consider their existence irrelevant, then valid alternatives to chemical awareness must be developed.

GLOSSARY

III



III

GLOSSARY

TECHNICAL TERMS

Addiction: A state of chronic intoxication produced by repeated consumption of a drug; its characteristics include (1) an overpowering desire or need to continue taking the drug and to obtain it by any means, (2) a tendency to increase the dose, (3) a psychological and physical dependence on the effects of the drug so that illness results from cessation of intake, and (4) a detrimental effect on the individual.

Amphetamines: Stimulant drugs, such as dexedrine, methedrine and benzedrine; commonly found in pep and diet pills. May be taken orally or injected. See "Stimulant".

Anticholinergic Substances: Such as belladonna, atropine, and scopolamine are commonly found in antispasmodic medications for the treatment of ulcers and asthma; also in non-prescription compounds for sleep, colds and composure. These drugs also inhibit secretions, drying out tissues, eyes and mouth; they flush the skin and dilate the pupils. In spite of these unpleasant side effects, there is some abuse of the asthmador cigarette, sought for its euphoric effects.

Barbiturates: A central nervous system depressant. Chronic misuse of barbiturates is accompanied by the development of tolerance and both physical and psychological dependence. Physical dependence appears to develop only with continued use of doses much greater than customarily used in the practice of medicine. In a physically dependent user, abrupt withdrawal is extremely dangerous, and should always be supervised by a physician. Barbiturates are the cause of many accidental deaths and suicides due to overdosage alone, or in combination with alcohol. Abusers may be emotionally erratic and aggressive.

Central Nervous System: The brain and spinal cord. (CNS)

Cocaine: A powerful central nervous system stimulant extracted from coca leaves; once medically used as a local anesthetic. It causes intense mental stimulation, feelings of extreme physical strength, and may cause unprovoked violent behavior and hallucinations. Though non-addicting, strong psychological dependence can develop, and depression and hallucinations may persist after withdrawal.

Combination Drugs: Drug abusers may use several drugs at one time, either to achieve the most pleasing effect, or to cut an expensive drug with a less expensive one. For example, amphetamine or scopolamine will potentiate the effects of LSD, and morphine is potentiated with barbiturates. The mental excitation of cocaine is decreased by combining it with heroin.

Convulsions: An involuntary and violent irregular series of contractions of the muscles.

Dangerous Drugs: "Dangerous drugs" is a legal term which applies specifically to barbiturates, amphetamines, and other drugs (except the narcotics) which are officially determined to have a potential for abuse because of their depressant, stimulant, or hallucinogenic effect on man. Federal control of the dangerous drugs is under the jurisdiction of the Food and Drug Administration, whereas federal control of the narcotics is under the jurisdiction of the Bureau of Narcotic Enforcement of the U.S. Treasury Department. In California, control of both narcotics and dangerous drugs is under the jurisdiction of the Bureau of Narcotic Enforcement.

Delirium: A condition characterized by mental excitement, confusion, disordered speech and, often, hallucinations.

Depressant: Any of several drugs which sedate by acting on the central nervous system to relieve pain, lessen nervousness, and produce sleep or stupor. Medical uses include the treatment of anxiety, tension, and high blood pressure. Many depressants produce physical dependence when used heavily but the great danger lies in overdosage and in withdrawal. Included in the depressants are the opiates and morphine synthetics, barbiturates, tranquilizers, solvents, anticholinergics, and alcohol.

DMT: Dimethyltryptamine, a non-addicting psychedelic drug; normal dose is 50 to 60 milligrams and the effects last about half an hour.

Drug: The term "drug" has been traditionally defined as "a medicine or a substance used in the making of medicine" and, when used within the context of the illegal use of drugs has been interchanged freely with the term "narcotics". Thus "drug addiction" has carried the same connotation as "narcotic addiction". However, the term "drug addiction" is rapidly being replaced with the term "drug dependence". The broader definition of "drug" takes into account the increasing number of nonmedical substances--for instance, volatile chemicals and certain hallucinogenic agents -- which are used today by persons who seek gratification from injecting, ingestion, smoking, or sniffing some nonfood substance into the body.

Drug Abuse: The term "drug abuse", covers the illegal self-administration of a wide range of substances, medicinal and nonmedicinal. The term does not refer solely to, nor does it excluse, narcotic abuse. It is a nonspecific covering term relating to the misuse of drugs, narcotics, chemicals, and other substances. This term is usually used in reference to agents which produce changes in mood and behavior.

Drug Dependence: The term "drug dependence" is gradually replacing the terms "addiction" and "habituation" in drug abuse literature. This development is most important since the use of the two terms has resulted in the erroneous impression that addiction, with its physical components which are sensationally evident in withdrawal illness, is the most serious manifestation of drug dependence and that habituation is of lesser importance because it functions merely on the psychological level. This impression is dangerous; it leads to the false conclusion that marijuana is "not dangerous" because it is "not addicting."

It is now recognized that psychological dependence, formerly called "habituation", is more complex and compelling than physical dependence - formerly called "addiction". It is known that physical dependence on heroin may be overcome, with suitable medical treatment, in a matter of 72 hours, whereas no means has yet been found to overcome psychological dependence on a drug.

Whenever possible, the term "drug dependence" should be used to indicate, without attempting to describe, the involvement of an individual with a drug. This term avoids the unfortunate connotations which cling to the terms "habituation" and "addiction" and even the more meaningful terms "psychological dependence" and "physical dependence". Drug dependence, whatever its nature, is complex. The distinction between its psychological and physical components is not yet fully understood by medical scientists. Certainly the layman should not presume to make the distinction.

As described in 1963 by WHO, drug dependence is "a state arising from repeated administration of a drug on a periodic or continuous basis." Its characteristics will vary with the agent involved. This is made clear by designating the particular type of drug dependence in each specific case - for example, drug dependence of the morphine type, of the cocaine type, of the cannabis type, of the barbiturate type, etc.

With "drug dependence" used in this frame of reference, it logically follows that "drug dependent" should replace "addict". However, "addict" continues to be used with respect to drug abuse. Ordinarily it is employed to describe a person who is deeply involved with drugs, usually narcotics, and who is reaching or has already reached the level of total dependence.

Euphoria: An extreme or exaggerated sense of well-being. Euphoric effects may be sought through the use of depressants, stimulants, and mild hallucinogens.

Habituation: As defined in 1957 by WHO, drug habituation is a condition, resulting from the repeated consumption of a drug, which includes these characteristics: (1) a desire (but not a compulsion) to continue taking the drugs for the sense of improved well-being that it engenders; (2) little or no tendency to increase the dose; (3) some degree of psychic dependence on the effect of the drug, but absence of physical dependence and, hence, no abstinence syndrome; (4) a detrimental effect, if any, primarily on the individual; a psychological dependence on a drug with a strong desire to continue taking the drug for the sense of improved well-being or satisfaction which it engenders, as distinct from the physical dependence of addiction.

Hallucinogen: Any of several drugs, popularly called psychedelics, which produce sensations such as distortions of time, space, sound, color and other bizarre effects. While they are pharmacologically non-narcotic, some of these drugs (e.g., marijuana) are regulated under Federal narcotics laws.

Hashish: A concentrated form of marijuana's active element, the resin obtained from the flowers of the cannabis plant.

Heroin An opiate and narcotic; an alkaloid from the poppy plant.

Hypnotic: An agent that induces sleep.

LSD: Lysergic acid diethylamide; by weight the most potent psychedelic drug; normal dose is 100 to 300 micrograms and the effects last from 8 to 10 hours; non-addicting.

Marijuana: A non-addicting drug obtained from the flowering tops of the cannabis or hemp plant; classified as a mild hallucinogen.

Mescaline: The pure, non-addicting alkaloid derived from peyote; normal dose is 300 to 800 milligrams and the effects last from 8 to 10 hours; classified as an hallucinogen.

Morphine; An opium derivative and a narcotic. Many morphine-like synthetics are now made.

Opiate: Any medicine containing or derived from opium. Opiates are the most medically effective pain-relievers in existence; used for short term acute pain and terminal illnesses. They are stringently controlled as narcotics because of their high physical dependence potential, their withdrawal syndrome, and high incidence of relapse.

Peyote: The unconcentrated preparation from the cactus plant, Anhelonium williamsii, non-addicting; classified as an hallucinogen.

Potentiation: Potentiation occurs when the combined action of two or more drugs is greater than the sum effects of each drug taken alone. Potentiation can be very useful in certain medical procedures. For example, physicians can induce and maintain a specific degree of anesthesia with a small amount of the primary anesthetic agency by using another drug to potentiate the primary anesthetic agent. Potentiation may also be dangerous. For example, barbiturates and many tranquilizers potentiate the depressant effects of alcohol.

Physical Dependence: Physiological adaption of the body to the presence of a drug. In effect the body develops a continuing need for the drug. Once such dependence has been established, the body reacts with predictable symptoms if the drug is abruptly withdrawn. The nature and severity of withdrawal symptoms depend on the drug being used and the daily dosage level attained.

Psilocybin: A non-addicting drug derived from a type of mushroom; normal dose is 20 to 60 milligrams and effects last 5 to 6 hours.

Psychedelics: A group of non-addicting drugs which alter perception and consciousness; with experience one can decrease the dosage and get the same effects; the more common types are marijuana, hashish, LSD, DMT, peyote, and mescaline; also referred to as mind or conscious expanding.

Psychological Dependence: An attachment to drug use which arises from a drug's ability to satisfy some emotional or personality need of an individual. The person feels the effects produced by the drug, or conditions associated with its use, are necessary to maintain an optimal state of well-being or to avoid discomfort. This attachment does not require a physical dependence, although physical dependence may seem to reinforce psychological dependence. An individual may also be psychologically dependent on substances other than drugs.

Psychosis: A major mental disorder; any serious mental derangement. "Psychosis" replaces the old term "insanity". Characterized by varying degrees of personality disintegration and failure to test and evaluate correctly external reality in various areas.

Sedative: An agent which quiets or calms activity.

Set: The personal variables of a psychedelic experience such as personality, expectations, values, anxieties, desires, and one's degree of self-understanding.

Setting: The external conditions of a psychedelic experience such as the surrounding or location, the people present, the size of the group, the time of day, the degree of privacy, and the experience of the guide.

Side Effects: A given drug may have many actions on the body. Usually one or two of the more prominent actions will be medically useful. The others, usually weaker effects, are called side effects. They are not necessarily harmful, but may be annoying. Novice users of certain drugs, such as marijuana, peyote, and household spices, may experience nausea and vomiting. With dosages large enough to produce a "high", these side effects usually subside as use continues. However, many side effects persist as long as the drug is used, and may actually be sought.

Stimulant: Any of several drugs which act on the central nervous system, producing excitation, alertness and wakefulness. Medical uses include the treatment of mild depressive states, and overweight. Stimulants include the amphetamines, caffeine and cocaine. Dangers of abuse include loss of appetite, irritability, and a disregard for fatigue. Excessive dosages may cause hallucinations and psychosis. Though non-addicting, tolerance develops and withdrawal from excessive use may cause severe depression; should be medically supervised.

Solvents: Non-drug substances of a volatile nature which lend themselves to inhalation. Sniffing glue, cleaning fluids, gasoline, paint thinners, etc., produces an intoxication with some unpleasant side effects. These substances are a dangerous depressant. The users risk respiratory failure or damage to liver, kidney, and bone marrow. Present knowledge indicates psychological dependence. Popular with children as young as 8 years.

STP: 4 methyl, 2, 5 dimethoxy alpha-methyl phenethylamine; a psychedelic chemical related to mescaline and amphetamine, said to be extremely mind-distorting, and lasting up to 72 hours.

Tolerance: With many drugs, a person must keep increasing the dosage to maintain the same effect. This characteristic is called tolerance. Tolerance develops with the barbiturates, with tranquilizers, with amphetamine and related compounds, and with opiates. An addicted person with a high tolerance might easily accommodate dosages which would kill a non-addicted person.

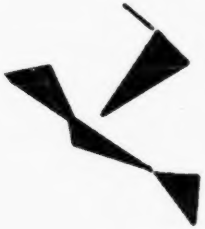
Toxic Effects (poisoning): Any substance in excessive amounts can act as a poison or toxin. With drugs, the margin between the dosage that produces beneficial effects and dosage that produces toxic or poisoning effects varies greatly. Moreover, this margin will vary with the person taking the drug.

Tranquilizers: Unlike barbiturate-type sedatives, this group of drugs can counteract tension and anxiety, and relax muscles without producing sleep or significantly impairing mental and physical function. Some minor tranquilizers (Miltown, Equinil, Librium) are addictive; repeated and excessive use may result in tolerance, plus physical and psychological dependence. The withdrawal symptoms are of a barbiturate nature.

Withdrawal Syndrome: A constellation of physical and/or mental changes which occur upon cessation of heavy use of certain drugs. These changes are specific for certain drugs or groups of drugs, i.e., alcohol, opiates, barbiturates and stimulants, each have specific patterns of symptoms.

Cross-Tolerance: When a person develops a tolerance for one drug, he may also develop a tolerance for other drugs. In the opiate user it is tolerance for synthetic pain relievers (Demerol) and in alcoholics for tranquilizers or barbiturates.

DRUG JARGON



IV

IV

DRUG JARGON and SLANG TERMS

Those who abuse drugs develop a special language that covers almost every aspect of the life associated with such abuse. This vocabulary often changes as one moves from one area to another. Teenagers sometimes pick up the language as slang. Thus the mere usage of the terms cannot be considered evidence of drug abuse.

"A"	Amphetamine sulphate
A-BOMB	Marijuana cigarette dipped in heroin
ACID	LSD
ACID-HEAD	An abuser of LSD
ACID SCENE	An area in which LSD is taken
ACID TEST	Party at which acid is added to punch
ACAPULCO GOLD	A "good" grade of marijuana
ACTION	Where "it's happening"
AFRICAN BLACK	A dark colored marijuana purportedly from Africa
AMP	Ampoule
AMPED	"Wired" on crystal or methedrine
ARTILLERY	Equipment for injecting drugs
AWSLEY	Reputed to manufacture very good LSD and STP
BACKTRACK	To withdraw the plunger of a syringe before injecting drugs to make sure needle is in proper position
BACKWARDS	A tranquilizer; any CNS depressant
BAD CAT	A good guy
BAD SCENE	A situation likely to produce a bum trip or distress
BAD SEED	Peyote
BAD TRIP	An unpleasant experience with LSD
BAD TRIP PANIC	Acute psychosis induced by LSD
BAG	Retail street unit of heroin; or do your own thing; preference and habit for a particular drug; one ounce of marijuana
BAGMAN	A drug supplier
BALL	A party; sexual intercourse
BALLOON	A small packet of narcotics
BANG	To inject drugs; to get high
BARBS	Barbiturates
BEAST, THE	LSD
BEAT, TO	To cheat
BEAN	Capsule
BEANS	Benzedrine
BEEN HAD	Arrested
BEHIND ACID	On an acid trip
BENNIES	"Benzedrine" (brand of amphetamine sulfate, Smith Kline & French Laboratories) tablets
BENNY	Intoxication after using Benzedrine
BENT OUT OF SHAPE	Under the influence of LSD
BERNICE	Cocaine
BIG CHIEF	Mescaline
BIG "D", THE	LSD

BIG JOHN	The police
BINDLE	A small quantity or packet of narcotics
BIRD'S EYE	Extremely small amount of narcotics
BIZ	Equipment for injecting drugs
BLACK ACID	LSD
BLACK AND WHITES	Patrol car
BLACK MOTE	Marijuana that has been cured in sugar or honey and then buried for a time
BLANKS	Poor quality narcotics
BLAST	Party
BLAST A JOINT	Smoke a marijuana cigarette
BLASTED	Under the influence of drugs
BLASTING PARTY	Marijuana smoking party
BLOOD	Negro, neutral term
BLOW (A stick, hay, jive, tea, pot)	To smoke a marijuana cigarette
BLOW THE VEIN	Too much pressure on a weak or sclerosed vein causing it to rupture
BLOW YOUR MIND	Unpleasant emotion; stark amazement; insanity
BLUE AND REDS	Tuinal, 50% Amytal Sodium -- 50% Secobarbital (Blue Tips)
BLUE ANGELS; BLUES	Sodium amytal capsules
BLUE BARRELS	LSD
BLUE BULLETS	Sodium Amytal
BLUE CHEER	LSD
BLUE DEVILS	"Amytal" (brand of amobarbital, Eli Lilly & Co.)
BLUE DOLLS	Sodium Amytal
BLUE HEAVENS	Sodium Amytal tablets or Morphine
BLUES	Sodium pentothal
BLUE VELVET	Paregoric and an antihistamine
BO-BO	Marijuana
BOMBIDO OR BOMBITA	Injectable amphetamine, heroin and/or barbiturate
BOOST, TO	To steal for narcotics supply
BOOT	Effect of a drug
BOSS	Good
BOXED	In Jail
BOY	Heroin
BREAD	Money
BROWN AND CLEARS	Dexedrine spansules
BUG	Annoy, bother, create hassles
BULL	A Federal narcotic agent, a police officer
BUM TRIP	An unpleasant experience with LSD
BUMMER	An unpleasant experience with LSD
BUNDLE	Quantity of heroin; 25 - $5 bags
BURN	To take money for heroin with no plans to deliver stuff, or phony drugs
BURNED	To receive phony or badly diluted drugs
BURNER	A habit
BUSH	Marijuana
BUSINESS	Paraphernalia for injecting narcotics
BUSINESSMAN'S SPECIAL	Nickname for DMT, a short acting hallucinogen
BUSTED	Arrested
BUTTON	Peyote
BUZZ	Try to buy drugs; slight "high" on glue

"C"	Cocaine
CACTUS	Peyote
C and H	Cocaine and heroin
C and M	Cocaine and morphine
CABALLO	Heroin
CAN	About one ounce of marijuana, Prince Albert tobacco can -- 1-1 3/4 oz.; jail
CANDY	Barbiturates
CAP	Number five gelatin capsule used to package drugs; the head; to put down
CARGA	Spanish for heroin
CARRYING	Carrying narcotics on one's person, e.g.; "Are you carrying?"
CARTWHEELS	Amphetamine sulfate (round, white, double-scored tablets)
CAT	Any male who swings or is cool
CATTLE-RUSTLER	Addict who steals meat and sells at a discount to support habit
CHAMP	Drug abuser who won't reveal his supplier - even under pressure
CHARGE	Marijuana
CHARGED UP	Under the influence of drugs
CHASING THE BAG	Trying different drug dealers for best quality
CHICK	Any female
CHIEF, THE	LSD
CHICAGO GREEN	Marijuana cured in opium
CHILL	To refuse to make a sale of narcotics to a suspected informer
CHIPPING	Taking small amounts of drugs on an irregular basis
CHIPPY	An abuser taking small, irregular amounts; a prostitute
CHRISTMAS TREE	Green and white time spansule containing a stimulant and a barbiturate or meprobamate
CLEAR UP	To withdraw from drugs
COAST-TO-COAST	Amphetamines
COASTING	Under the influence of drugs
COKE	Cocaine
COKED UP	Under the influence of cocaine
COKIE	A cocaine addict
COLD: COLD TURKEY	Sudden drug withdrawal
COLUMBUS BLACK	Marijuana
CONNECT	To purchase drugs
CONNECTION	A drug supplier; an intermediary
COOKER	Any spoon or bottle cap used in the preparation of heroin
COOL	Good
COOK UP A PILL	Small amount of water added to a powdered drug and heated in a spoon before injecting
COME ON	Drug starting to take effect
COMING DOWN	Emerging from an LSD experience
CONTACT HIGH	Becoming high from contact with drug users
CO-PILOTS	Amphetamine tablets
COP: COPPING	To purchase drugs
COP-OUT	To alibi, confess: sell out to establishment: succumb to conventional pleasures
COPE	To carry on while under influence of drugs
CORAL	Chloral hydrate
CORINE	Cocaine
COTICS	Narcotics

COTTONHEAD	User who recooks the cotton fibers found in cookers when their supply is used up and they are in need of an injection
COTTON TOP	User who recooks the cotton fibers found in cookers when their supply is used up and they are in need of an injection
COUNT	Amount or purity of a drug
COWBOYS	Independent operators dealing in drugs
CRACKERS	LSD
CRANK; CRINK; CRIS: CRISTINA	Methamphetamine in powdered form
CRASHING	Depression following cessation of amphetamine use; come-down hard from a high or trip
CRAZY	Really with it; odd or different from establishment
CROSSROADS; CROSS TOPS	Scored tablets of amphetamines
CRUTCH	Holder used to smoke a "roach" down short
CRYSTAL	Methamphetamine in powdered form or cocaine crystals
CUBE	Non user of drugs; sugar cube impregnated with LSD
CUBEHEAD	Regular user of LSD
CUNT	An area of vein favored for injection
CUT	To adulterate a narcotic by adding milksugar
CUT OUT	Leave
DABBLE	To take small amounts of drugs on an irregular basis
D.D	A fatal dose of narcotics or other drugs
DEALER	A drug supplier
DECK	A small packet of narcotics
DEXIES; DEX	"Dexedrine" (brand of dextroamphetamine sulfate, Smith Kline & French Laboratories) tablets
DICE	Desoxyn, methamphetamine
DIG	Listen; like
DIGGER	One who works; a swinger
DILLIES	Dilaudid, dihydromorphinone
DIME BAG	A ten-dollar purchase of narcotics
DIRTY	In possession of narcotics
DITCH	Inside of the elbow which has two large veins
DO DOPE, DO UP	Use drugs
DOING THE DOZENS	Getting the required number of fixes to support a narcotic habit
DOLLAR	One hundred dollars
DOLLIES	"Dolophine" (brand of methadone hydrochloride, Eli Lilly and Company) tablets
DOMINO	To purchase drugs
DOOJEE	Heroin
DOPE	Any drug; marijuana
DOPE FIEND	Term used by drug users to parody society's view of them
DOPER	Drug user
DOUBLE TROUBLE	"Tuinal" (brand of amobarbital sodium and secobarbital sodium, Eli Lilly and Company) capsules
DO A THING	Take drugs
DO UP	Smoke marijuana cigarette; use any drug
DOUBLE CROSS	Either "two ways" or "four ways"

DOWNER; DOWNS	Any depressant or sedative
DRIPPER	Paraphernalia for injecting narcotics; eyedropper
DROP	(to drop) to take by mouth
DROP A DIME	Report someone to the police by sending a letter; call police to cause a raid or arrest
DROP OUT	To detach yourself from wordly commitments
DROPPED	Arrested
DROPPER	Paraphernalia for injecting narcotics
DUBIE	A marijuana cigarette butt
DUST	Cocaine
DYNAMITE	Narcotics of high potency
EGO GAMES	A deprecative term applied by LSD users to social conformity and to the normal activities, occupations, and responsibilities of the majority of people
EIGHTH	Eighth of an ounce
ENDS	Money
EYE OPENERS	Pep pills
EXPERIENCE	An LSD "trip"
EXPLORERS CLUB	A group of acid heads
FACTORY	Equipment for injecting drugs
FAR OUT	Unusually high; extraordinarily bizarre; avante garde
FIFTEEN CENTS	Fifteen dollars
FINE STUFF	Well-manicured marijuana
FINK	Informer, usually under cover
FIT	Paraphernalia for injecting narcotics
FIX	An injection of narcotics
FLAKE	Cocaine
FLASH	Initial and intense response to drug felt throughout the body; may be preferred by I.V. users over secondary euphoric effects
FLASHBACK, FLASH, OR RETRIPPING	Recurrence of a drug experience without additional dosage
FLASHOUT	Passing out momentarily from glue sniffing
FLAT-FOOTED HUSTLER	Addict who will commit any kind of crime for money
FLEA POWDER	Poor quality narcotics
FLIP, TO	To go psychotic or crazy
FLOATING	Under the influence of drugs
FLOWER CHILDREN	Passive, peace-living "hippies"
FLY	Take narcotics
FLYING HIGH	Under the influence of marijuana
FOIL	Small packet of narcotics
FOOTBALLS	Oval-shaped amphetamine sulfate tablets
FOUR WAYS	A combination of LSD, STP, methedrine, and strychnine or cocaine
FOURS	Empirin compound with codeine gr. 1
FORWARDS	Stimulant drugs
FRANTIC	Need or desire for narcotics
FREAK	Used to refer to users of aggressive drugs, as in "speed freak"; become afraid; wild sex; a crazy thing or person; nickname for hippies
FREAKING OR FREAKING FREELY	Behavior while on LSD

FREAK OUT	To have an unpleasant reaction while on a "trip"; to be psychotic-like
FRESH AND SWEET	Out of jail
FRONT	Payment in advance of delivery of drugs
FRUIT SALAD	Assortment of pills jumbled in a sack; then a handful taken by mouth
FUZZ	The police
GAGE	Marijuana
GASKET	Anything that can be placed on the small end of an eyedropper to prevent air from leaking between dropper and the needle
GASSING	Sniffing gasoline fumes
GEE	Intravenous injection
GEE-HEAD	Paregoric abuser
GEETIS	Money
GEEZER	A narcotic injection
GEE[illegible]ING	To take
GET DOWN A CAP	Using or sharing a capsule (often heroin)
GET HIGH	Smoke a marijuana cigarette
GHOST, THE	LSD
GIGGLE-SMOKE	Marijuana
GIMMICKS	Equipment for injecting drugs
GLAD RAG; WAD	Cloth material or handkerchief saturated with a chemical
GLUEY	Glue sniffer
GO	To get into the swing of things
GOLD	Marijuana
GOLD DUST	Cocaine
GOODS	Narcotics
GOOFBALLS; GOOFERS	Barbiturates
GOOF BUTT	Marijuana
GOOFED UP	Under the influence of barbiturates or narcotics
GOW-HEAD	An opium addict
GRAPES	Wine
GRASS	Marijuana
GRASS-HEAD	One who uses marijuana
GRASSHOPPER	Maijuana user
GREASE	Midwestern term for amphetamine
GREEN	Marijuana
GREEN AND CLEARS	Dexamyl spansules (Dexedrine and Amobarbital)
GREEN DOUBLE DOMES	LSD
GREEN SINGLE DOMES	LSD
GREENIES	Green, heart-shaped tablets of dextroamphetamine sulfate and amobarbital
GRIEFO	Marijuana
GROCERY FENCE	Local businessman who buys stolen goods and sells to customers at a discount; may be bar owner or beauty parlor owner, etc.
GROOVE	To enjoy very much
GROUNDMAN, GROUND CONTROL, SITTER, OR GUIDE	Means one who stays with an LSD user but doesn't take the drug himself
GUN	A hypodermic needle

GURU	Companion on a trip who has tripped before; person who acts as teacher and guide in fundamental intellectual concern
"H"	Heroin
HABIT	Narcotic habit
HALF-LOAD	Fifteen, $3 bags of heroin
HALF-BUNDLE	Ten, $5 bags of heroin
HAND-TO-HAND	Person-to-person delivery
HANG-UP; TO BE HUNG UP.	A personal problem; ensnared in conflicts
HAPPENING	An experience obtained through the use of lights and sounds; to have the same type of experience that one has with a drug; a spontaneous event
HAPPY DUST	Cocaine
HARD CANDY	Heroin
HARD STUFF	Morphine, cocaine or heroin
HARNESS BULLS	Uniformed officers
HARRY	Heroin
HASH; HASHISH	A potent form of marijuana
HASSLE	Unwelcome duty or intrusion into one's life or mental equilibrium
HAWK, THE	LSD
HAY	Marijuana
HAYHEAD	Marijuana user
HEAD	Used to refer to users of psychedelic drugs; a "high"
HEAD-THING	Qualitative or quantitative thinking increased under influence of LSD
HEARTS	"Benzedrine" or "Dexedrine" (brands of amphetamine sulfate and dextroamphetamine sulfate, Smith Kline & French Laboratories) heart-shaped tablets
HEAT	Police
HEAVENLY BLUE and PEARLY GATE	Other name for morning glory seeds containing lysergic acid derivatives
HEELED	Having narcotics; having money
HEMP	Marijuana
HIGH	Under the influence of drugs
HIPSTER	Group minded, conforming, partly"hip" person
HIT	To purchase drugs; an arrest; an injection of narcotics
HITTING IT	Adulteration of heroin, usually 1 to 1, before selling it
HOCUS	A narcotic solution ready for injection
HOLDING	Possessing narcotics
HOOKED	Addicted
HOPHEAD	Narcotic addict
HOPPED UP	Under the influence of drugs
HORN	To sniff powdered narcotics into nostrils
HORSE	Heroin
HORSE HEARTS	Dexedrine
HOT	Wanted by police
HOT SHOT	A fatal dosage
HUBBLE-BUBBLE	Waterpipe used for smoking marijuana
HUSTLE	To rob or steal; to solicit favors, money, etc.
HYKE	Hycodan, dioxcodinone hydrochloride
HYPE	Narcotic addict

ICE CREAM HABIT	A small, irregular drug habit
INDIAN HAT	Marijuana
INFORMER	One who gives police information
"J"	A marijuana cigarette
JAB; JOB	To inject drugs
JAG	Intoxication after using benzedrine or glue
JACKING OFF THE SPIKE	Pulling blood from the vein into the syringe to rinse all of the drug into the vein
JIVE; JIVE STICK	Marijuana
JOINT	A marijuana cigarette; paraphernalia for injecting heroin; prison
JOLT	An injection of narcotics; effects of the drug
JONES	The habit, an addict
JONING; BIG JONES; JONES; RIGHTEOUS JONES	The supporting of a heroin habit
JOY PLANT	Opium
JOY-POP	To inject small amounts of drugs irregularly
JOY-POPPER	Occasional user of narcotics
JOY-POWDER	Heroin
JOY-SMOKE	Marijuana
JUGGLER	Sells drugs on street for only enough profit to support own habit
JUICE	"Hard" liquors
JUNK	Narcotics
JUNKIE	A narcotic addict
JUVIES	Juvenile officers
KANSAS GRASS	Poor grade of marijuana
KI; KEY; KEE	2.2 lbs. or a kilo of marijuana
KICK; KICKS	To abandon a drug habit; effect of drug; thrills
KICK PARTIES	Parties or sessions where LSD is used
KILO	Large amount of narcotics
KIT	Paraphernalia for injecting narcotics
KNOCKED OUT	Under the influence of narcotics
L.A.	Long-acting amphetamine
LACE	Money
LAY BACK	Barbiturates
LAYOUT	The equipment for injecting drugs
LEAF, THE	Cocaine
LEDGE	A jumping off place for "trips." A meeting place for addicts and acid-heads
LID	4-1/2 match boxes of marijuana (Prince Albert can); about one ounce of marijuana
LID POPPERS	Amphetamine
LIME ACID	LSD
LIPTON TEA	Poor quality narcotics
LIT UP	Under the influence of drugs
LLESCA	Spanish word for marijuana
LOCOWEED	Marijuana
LONG GREEN	Money

"M"	Morphine
M.S.	Morphine sulphate
MARY WARNER	Marijuana
MU	Marijuana
MACHINERY	Equipment for injecting drugs
MAGIC MUSHROOMS	Sources of hallucinogens
MAINLINE	To inject drugs directly into a vein
MAINLINER	One who injects drugs into a vein
MAKE A BUY	To purchase drugs
MAKE A MEET	To purchase drugs
MAN, THE	The police; one's connection; white people
MANICURE	To remove seeds or stems from marijuana
MARY JANE	Marijuana
MATCH BOX	Marijuana container; 5 to 8 reefers; 1/5 of a lid; nickel or dime bag
MEET	Appointment between an addict and a peddler
MELLOW YELLOW	Supposedly bananas used as drugs (skins, dried and smoked)
MEMBER	Negro or some other than a white person
MESC	Mescaline
METH-HEAD	One who uses methedrine only; also called speed freak
MEXICAN BROWN	Brown marijuana from Mexico
MEZZ	Marijuana
MICKEY FINN	Chloral hydrate
MILK A RUSH	To inject slowly or pump to savor effect
MISS	Missing the vein and accidentally injecting into the tissue
MISS EMMA	Morphine
MISTER BLUE	Snythetic morphine
MOHASKY	Marijuana
MOJO	Narcotics
MONKEY	A drug habit where physical dependence is present
MOON; HALF-MOON	Peyote
MOOTERS	Marijuana
MOR A GRIFA	Marijuana
MORPHO	Morphine
MOTA	Mexican word for good marijuana
MUGGLEHEAD	Marijuana user
MUGGLES; MUGGIES	Marijuana
MUNCHIES, OR MARIJUANA MUNCHIES	Vigorous increase in appetite, often experienced after smoking marijuana
MUSCLE	To inject a drug intramuscularly because one can't find a good vein, to conceal the needle mark or to lengthen the effects of the drug
MUTAH	Marijuana
NAB	Police
NARC	Police officer (the law)
NEEDLE	Hypodermic syringe
NEEDLE FLASH	A short high that might come between the time the needle enters the tissue and the drug enters the blood stream
NEEDLE FREAK	One who gets a thrill out of using the needle
NICKEL BAG	A five-dollar purchase of narcotics
NIMBY	Nembutal (brand of penobarbital, Abbott Laboratories) capsules

NUMBER	Marijuana cigarette
NUMBER FIVE	Designed size of small hypodermic needle
"O"	Opium
O.D.	Overdose of narcotics or other drugs
OFF	Withdrawn from drugs
ONE WAY	LSD
ON A RIP	Under the influence of LSD
ON A TRIP	Under the influence of LSD or other hallucinogens
ON THE BEAM	Under the influence of marijuana
ON THE NOD	Under the influence of drugs (usually narcotics)
ON THE STREET	Out of jail; drug traffic and life on street
ON THE STUFF	Regular user or addict
OP	Opium
ORANGE CUPCAKES	A combination of LSD, STP, "speed", and strychnine or cocaine
ORANGE WEDGES	LSD
ORANGES	"Dexedrine" (brand of dextroamphetamine sulfate, Smith Kline & French laboratories) tablets
OUNCE (Good, cut, street or vig)	Varying strengths of heroin in order of adulteration
OUTFIT	Eye dropper, cooker (spoon or bottle cap) used to prepare fix
OUT OF THE BODY	The feelings of a person while under the influence of LSD
OUT OF SIGHT	So good words fail to describe it
OUT OF THIS WORLD	Under the influence of marijuana
OUTSIDE MYSELF	The feelings a person experiences while he is under the influence of LSD
OVER-AMPED	Very high on speed
OWSLEY	See Awsley (Reputed to manufacture very good LSD and STP)
"P"	Peyote
PACIFIER	Homemade syringe and needle, partly from a pacifier
PACK	Heroin
PAD	Drug user's home
PANAMA RED	Reddish colored marijuana purportedly from Panama
PANIC	Critical shortage of heroin supply throughout an area
PAPER	A prescription; packet of narcotics; roll-your-own marijuana paper
PAPER BOY	A dealer in heroin
PARANOID	One who is afraid - suspicious
PASS	A "Pass" is actual transfer of drugs
PAT	Marijuana
PEACHES	"Benzedrine" (brand of amphetamine sulfate, Smith Kline & French Laboratories) tablets
PEANUTS	Barbiturates
PEDDLER	Dealer in drugs
PER	Prescription
P.G. OR P.O.	Paregoric
PHENNIES	Phenobarbital
PIECE	A container of drugs or a large amount, usually heroin; one ounce; a gun-pistol; a girl
PIGS	Policemen
PILL FREAK	Dangerous drug user; one who takes lots of pills

PILL HEAD	Dangerous drug user; one who likes to get "high" on pills
PILLY	Dangerous drug user
PINK WEDGES	A combination of LSD, STP, "speed", and strychnine or cocaine
PINK WITCHES	LSD
PINKS	"Seconal" (brand of secobarbital, Eli Lilly and Co.) capsules
PIPE	A large vein
PLANT	A cache of narcotics; placing drugs on a person to get him caught
PLASTIC	Half-commited, pseudo-hippie; artificiality of middle class; rigid person
POINT	Hypodermic needle
POP	To inject drugs under the skin
POPPERS	Amylnitrite, used for sexual stimulation
POT	Marijuana
POTHEAD	Marijuana user
POWDER	Amphetamine in powdered form
PUMP-UP	Move muscles to make vein pop out for injection
PURE	Pure narcotics of very good grade
PURPLE FLATS	LSD
PURPLE HAZE	Owsley's acid (LSD)
PURPLE WEDGES	LSD
PUSHER	Narcotic seller
PUT DOWN, TO BE	To be degraded, disapproved of, made to feel inferior
QUILL	A folded match cover or dollar bill from which narcotics are sniffed through the nose, used as a straw
RAINBOWS OR TOOIES	"Tuinal" (brand of amobarbital sodium and secobarbital sodium, Eli Lilly & Co.) capsules
RAINY DAY WOMAN	Marijuana cigarette
RAP	To talk; to inform (rare)
RAT; RAT OFF	To inform
READER	A prescription
RED DEVILS; RED BIRDS; RED; PINKS; RED BULLETS; RED DOLLS	"Seconal" (brand of secobarbital, Eli Lilly & Co.) capsules
REEFER	Marijuana cigarette
REGISTER	When the blood appears in the outfit indicating the vein has been punctured
RHYTHM	Midwestern term for amphetamines
RIFF, TO	To lie
RIG	Injection equipment
RIGHTEOUS	Very good grade of drug
RIPP OFF, TO	To steal, to hold up
RIPPED	Under the influence of drugs, usually grass or speed
RIPPING AND RUNNING	Old term for activities involved in supporting a narcotic addiction
RIVEA CORYMBOSA and IMPOMOEA VIOLACEA	Species of morning glory seeds in which lysergic acid is found
ROACH	The butt of a marijuana cigarette
ROACH HOLDER	Rolled up match cover
ROBE; ROBO	Robitussin cough syrup containing codeine

ROLLER	A vein that rolls out from under a needle when trying to inject
ROPE	Marijuana
ROSES	"Benzedrine" (brand of amphetamine sulfate, Smith Kline & French laboratories) tablets
RUMBLE	Police in the neighborhood; a shake-down or search
RUN, RUNS	Continuous use of speed for prolonged periods
RUSH	Tremendous impulse of energy because of amphetamine injection
SAM	Federal narcotic agents
SATCH	Saturated paper or articles of clothing, such as handkerchiefs, upper part of undershirt or chemise, etc., used to smuggle narcotic drugs to prisoners
SATCH COTTON	Cotton used to strain narcotics before injection
SCAT	Heroin
SCENE	Action occurring during drug use; may be any occurrence
SCHOOLBOY	Codeine
SCOPE	To look at
SCORE	To obtain drugs, sex, concrete goods or recognition; when blood appears in the syringe
SCRIPT	Doctor's prescription
SCRIPT WRITER	Sympathetic doctor; forger of prescriptions
SEGGY; SECCIE	"Seconal" (brand of secobarbital, Eli Lilly & Co.) capsules
SHIT	Heroin; sometimes marijuana
SHOAT	A dose or narcotics
SHOOTING GALLERY	A place where narcotic addicts inject drugs
SHOOT UP	To inject drugs
SHORT	A car
SHORT COUNT	Misrepresentation of weight in a unit of heroin
SICK	Need for narcotics
SILK	A white person
SILVER BIKE	Syringe with chrome fittings or a chrome hypodermic needle
SIMPLE SIMON	Psylocibin
SITTER	An experienced LSD user who helps or guides a new user
SKAG	Heroin
SLAM	Jail or prison
SLAMMED	In jail
SMACK	Heroin; to sniff powdered narcotics into the nostrils
SMECK, SMACK OR SCHMECK	Heroin, narcotics (derivative of smeck, Yiddish term for "to sniff")
SMOKE	Marijuana
SNEEZE IT OUT	Kick the habit
SNIFF	To sniff narcotics (usually heroin or cocaine) through the nose
SNORT; SNORTING	To sniff powdered narcotics into nostrils
SNOW	Cocaine; white heroin
SNOWFLAKE	Cocaine
SNOW BIRD	Cocaine user
SOCH	"Straight" student body leaders
SPACE or SPACE OUT	Out of communication, under drug influence
SPADE	A colored person, usually a swinger
SPEED	Methedrine

SPEED DEMON	Stimulant user
SPEED FREAK	Stimulant user
SPEEDING; SHOOTING SPEED	Taking amphetamines intravenously
SPEEDS	Any drug used as a stimulant
SPEEDSTER	Stimulant user
SPEEDBALL	An injection which combines a stimulant and depressant - often cocaine mixed with morphine or heroin
SPIKE	The needle used for injecting drugs
SPLASH	Midwestern term for all amphetamines
SPLASH HOUSES	Places where amphetamines are injected
SPLASH PARTIES	Parties where amphetamines are injected
SPLASHING	Injecting amphetamines
SPLIT	To leave
SPLIVEN	Midwestern term for amphetamines
SPOON	Sixteenth of an ounce of heroin
SQUARE	A non-addict; derogatory term for persons of rigid conventional beliefs
STACK	A quantity of marijuana cigarettes
STAR DUST	Cocaine
STASH	A cache of narcotics
STEALING COPPER	Pilfering metal and fixtures from empty buildings and selling to junkmen to support addiction
STEAM ROLLER	Smoke a marijuana cigarette with empty toilet paper roll on end
STICK	A marijuana cigarette
STONED	Under the influence of narcotics
STOOL	Informer
STRAIGHT	Neutral term for person conforming to conventional society
STRAWBERRY FIELDS or FLATS	LSD
STRAWBERRY SHORTCAKES	Obedrin L.A. (diet pill)
STRUNG OUT	Dependent upon and continuously using a drug
STUFF	Narcotics
SUGAR	Powdered narcotics
SUGAR DOWN	To cut narcotics
SUPERGRASS	High potency marijuana
SUPPLIER	Drug source
SWINGER	Someone who is usually "with it"
SWINGMAN	A drug supplier
"T"	Marijuana
TAB	Tablet
TAKE A BAND	Take drugs
TAKE-OFF	Take drugs
TAKE UP	Light a marijuana cigarette
TAKEN OFF	Addicts being robbed by other addicts while in possession of drugs or money
TAKING CARE OF BUSINESS	Total life involvement and activities of drug addicts (heroin)
TAPPING THE BAG	Taking out a little drug before selling
TASTE	Small quantity of narcotics usually given as sample or reward
TEA	Marijuana
TEAHEAD	Marijuana user

TEA PARTY	Marijuana smoking party
TEENY-BOPPER	A young adolescent
TEXAS TEA	Marijuana
THE MAN	Dealer in drugs
THINGS	Various amounts of a narcotic
THORNS	Hypodermic needles
THOROUGHBRED	A high-type hustler who sells pure narcotics
TICKET	Drug used for hallucinogenic trip
TICKET AGENT	Supplier of hallucinogens
TIE OFF	Tourniquet used in injecting
TO BE HEP	To understand; "with it"; experienced
TO BE HIP	To understand; "with it"; experienced
TO HAVE SAVVY	To understand
TO HIT ON	To try to buy drugs
TO MAKE IT	To try to buy drugs
TOKE	Particular way of inhaling a marijuana cigarette. Increases the rate of absorption by the person's system
TOOIES	"Tuinal" (brand of amobarbital sodium and secobarbital sodium, Eli Lilly & Co.) capsules
TOOLS or WORKS	Equipment used for injection by hypodermic
TOPS	Peyote
TORCH UP	Light a marijuana cigarette
TOSS	Search
TOYS	Purified opium (dark brown sticky mass) in small boxes sold to addicts; eaten or smoked
TOXY	The smallest container of prepared opium
TRAVEL AGENT; TOUR GUIDE	An experienced LSD user who helps or guides a new user; on west coast, a supplier of LSD
TRACKS	Needle marks left from injections
TRIP	Specific emotional reaction, i.e., ego trait, hate trips, love trips, also the experience one has when under the influence of LSD
TRIP OUT	To experience a very subjective "trip" feeling, not necessarily from drug use
TRUCK DRIVERS	Amphetamines
TUNING IN	Feeling the effects of LSD; getting with an experience or person
TURKEY	A capsule purported to be narcotic but filled with a non-narcotic substance
TURN ABOUTS	Long acting amphetamines
TURNED OFF	Withdrawn from drugs, people, or uninteresting situations
TURNED ON	Under the influence of drugs; feeling intensely alive
TWENTY-FIVE	LSD
TWIST	Marijuana cigarette
TWO WAYS	LSD and STP combined
UNCLE; UNCLE SAM	Federal narcotic agent
UNCOOL	One so unable to cope with "modern scene" that he is considered dangerous and ostracized
UNDERGROUND	Inhabitants and activities of "hippie" world
UP	On drugs; on a trip
UP TIGHT	Angry, tense, nervous

UPPERS; UPS	Stimulants, especially benzedrine or dexedrine
UTOPIATES	The hallucinogenic drugs
VALLEY	The inside of the elbow which has two large veins
VIBRATIONS	Non-verbal communication
VIC	One who has been given a hot shot, a victim
VODKA ACID	Vodka that contains LSD, supposedly the most effective and available preservative for the drug
VOYAGE	Experience under LSD
WAFER	Wafer impregnated with LSD
WAKE-UPS	Amphetamine
WASHED UP	Withdrawn from drugs
WASTED	Under the influence of drugs
WATER	Methedrine, in solution, used intravenously
WAY OUT	On marijuana
WEED	Marijuana
WEED-HEAD	Marijuana user
WEEKEND HABIT	A small, irregular drug habit
WHERE IT'S AT	Real and significant activity as opposed to sham and ritual
WHISKERS	Federal narcotic agents
WHITE DOUBLE DOMES	LSD
WHITE LIGHTNING	LSD
WHITE SINGLE DOMES	LSD
WHITES	Amphetamine sulfate tablets
WHITE STUFF	Morphine
WIG	The mind
WIGGY	Mentally ill
WIGOUT	Blow one's mind
WIRED	Under the influence of narcotics
WORKS	The equipment for injecting drugs
YATA	Mexican slang for someone who is crazy
YELLOW-JACKETS; YELLOW DOLLS; YELLOW BULLETS YELLOWS	"Nembutal" (brand of pentobarbital, Abbott Laboratories) capsules (solid yellow)
YEN	Desire for narcotics
YEN HOOK (HOCK)	Instrument used in opium smoking
YEN SHEE	Opium ash
YEN SHEE SUEY	Opium wine
YOUNGBLOOD	Young person starting to use marijuana
ZUNKED	Under the influence

DRUG INFORMATION

V

V

DRUG INFORMATION

DRUGS OF ABUSE AND THEIR EFFECTS

1. INTRODUCTION

A drug is any substance, other than food, which affects body structure or function. This broad definition includes the increasing number of non-medical substances which are used today by persons who seek gratification from injecting, ingesting, smoking, or sniffing some non-food substance into the body.

Drug abuse is the use, by self administration, of any drug in a manner which deviates from medical approval and which may act to the possible detriment of the individual, of society, or both.

Substances with abuse potential range from simple kitchen spices through common flowers and weeds to highly sophisticated drugs. This chapter includes the following:

1. Introduction
2. Narcotics
3. Depressants
4. Stimulants
5. Psychedelics or Hallucinogens
6. Marijuana
7. Miscellaneous Drugs of Abuse
8. Profit Motive

Medically defined, narcotics are drugs that produce sleep or stupor and relieve pain. This applies principally to the opiate family and its derivatives (morphine, codeine, and heroin), and synthetic opiates (meperidine and methadone). Narcotics are regulated by the Federal Bureau of Narcotics as is cocaine, a dangerous stimulant, and marijuana, now classified as a hallucinogen. All other drugs susceptible to abuse are non-narcotics. However, stringent federal control over barbiturates, amphetamines, some tranquilizers, and hallucinogens, all classified as dangerous drugs because of their abuse potential, falls under the jurisdiction of the Bureau of Drug Abuse Control, part of the Food and Drug Administration.

Most of the above drugs are essential to the practice of modern medicine and to medical research. Use by the abuser stems from other motivations: the drugs affect the central nervous system, producing a change in emotional response and reactions. The abuser may feel exhilarated, relaxed, intoxicated, happy, or detached from a world that is painful and unacceptable to him. All substances abused can produce changes in behavior or mood, particularly when large amounts are improperly used. These changes may be harmless or may constitute a danger to both the abuser and society.

In discussing the drugs and their effects it becomes apparent immediately that little is known regarding the long term effects of abuse on either a physical or psychological level. While much is known about the physical properties of the specific drugs, less is known about the exact functional changes they produce in the central nervous system and even less known about their effect on psychological functioning. Seeming paradoxes and inconsistencies in drug effects are due:

1. to our lack of knowledge of these functional changes and
2. to the fact that the influence of drugs is highly dependent on other factors -- physiological, psychological, and environmental and
3. the effects of drugs may vary greatly with the individual.

With drug abuse certain conditions arise. The effects and consequences of drug abuse are characterized in terms of these conditions. Drug abusers may develop any one or all of the following:

1. An emotional or PSYCHOLOGICAL DEPENDENCE on the drug and a desire for its effects.
2. A PHYSICAL DEPENDENCE whereby the body, having adapted to the drug, now needs it.
3. WITHDRAWAL ILLNESS - An array of symptoms, different for each drug, which may occur when a drug is discontinued. This illness is always a result of physical dependence, and usually subsides with proper care in about 72 hours. Psychological dependence does not usually subside without therapy, and is the cause of a person resuming drug use. Its manifestations upon withdrawal may be referred to as after-effects.
4. TOLERANCE - Build-up to the drug so that more and more is needed for the desired effect.

Each drug is discussed with these conditions in mind in addition to medical use, side and toxic effects, and motivations for use. You may wish to refer to the glossary for a more detailed accounting of these conditions and a thorough discussion of the terms "habituation," "addiction" and "drug dependence."

2. NARCOTICS

Opiates:

Medical Use

Natural opiate derivatives (morphine, heroin, paregoric, codeine, Dilaudid, and Percodan) and morphine synthetics (meperidine or demerol and methadone or dolophine) are the most effective pain relievers in existence. They are widely used for short-term acute pain resulting from surgery, burns, etc., and in the terminal stages of cancer.

The depressant effect of opiates produces drowsiness, sleep and a reduction in physical activity. Side effects can include nausea and vomiting, constipation, itching, flushing, contraction of pupils and respiratory depression.

Reasons for Abuse

The appeal of morphine-like drugs lies in their ability to reduce sensitivity to both psychological and physical stimuli and to produce a sense of euphoria. These drugs dull fear, tension, and anxiety. Under the influence of the opiates the addict is usually lethargic and indifferent to his environment and personal situation.

Dependence and Tolerance

Chronic use may lead to both physical and psychological dependence. Psychological dependence is the more serious of the two generally, since it is still operative after completion of physical withdrawal. Tolerance develops, and with an ever-increasing need for the drug, the addict's activities become increasingly drug-centered. This may result in a total preoccupation concerned with delicately balancing "highs," fighting tolerance, and obtaining drug supplies. Total drug involvement may require $30 to $150 per day to support it. Since many addicts cannot work in a drugged condition, stealing is often their means of income.

Withdrawal

When drug supplies are cut off, characteristic withdrawal symptoms develop. Many addicts use the avoidance of these excruciating symptoms as a reason for continuing the use of these drugs. Symptoms include nervousness, anxiety, sleeplessness, sweating, eyes and nose running, muscle spasms, severe aching in legs and back, vomiting, diarrhea, and a feeling of desperation and an obsessional desire to secure a "fix." The intensity of symptoms varies with the degree of physical dependency. Some symptoms may persist for several weeks.

Dangers of Abuse

Most "street" heroin is cut so much with filler that addicts get only 3% to 10% heroin in a "bag." In the event an addict buys a supply containing considerably more than his accustomed dose, he can die from overdosage (O.D.). Opiates are taken either by sniffing or by injecting under the skin or in the vein. As in all drug abuse involving careless injections, hepatitis, blood poisoning, tetanus, and abscesses may occur due to contaminated injection equipment. There seems to be no evidence of physical damage directly due to chronic use of opiates, but because of an addict's lack of concern for himself or surroundings, and a loss of appetite, he may suffer severe weight loss, malnutrition, lowered resistance to infection and a general devitalized condition.

Exempt Narcotics:

Some preparations containing small amounts of narcotics are exempt from prescription requirements. These products include certain cough medicines and paregoric remedies which may be sold "over the counter" in pharmacies.

Medical Use

1. Paregoric - a liquid containing an extract of opium used to counteract diarrhea and relieve abdominal pain.

2. Codeine - found in cough formulas to combat symptoms of respiratory disorders, an effective cough suppressant in small quantities.

Abuse

Very large quantities of these preparations are consumed by narcotic abusers when narcotic supplies are short. School students are known to abuse these two medications. A number of cough remedies contain a high alcohol content (elixirs) which may add to their attraction. Some elixirs contain as much as 40% alcohol.

3. DEPRESSANTS and TRANQUILIZERS

Barbiturates:

Barbiturates not only comprise the largest group of central nervous system depressants, but along with the tranquilizers, probably represent the most used and abused of all the depressants (except alcohol). Barbiturates are considered to have sedative-hypnotic properties, but unlike the narcotics, do not have the power to relieve pain. They have the power to depress a wide range of functions, including those of nerves, skeletal muscle, smooth muscle, and cardiac muscle. Their effects on the central nervous system vary from mild sedation to coma, depending on the dosage level. Sleeping pills are the most commonly abused form.

The "street" name is "goofballs." Other slang terms arise from the color and shape of the particular product (i.e., Nembutal is called "yellow jackets," Seconal is called "red devils" etc.).

Medical Use

Under medical supervision barbiturates are impressively safe and effective in every kind of illness requiring sedation: high blood pressure, insomnia, epilepsy, diagnosis and treatment of mental disorders.

Reasons for Abuse

At the onset, barbiturates produce relaxation, lassitude, and a reduction in tension. They may produce euphoria or a "high." The underlying reasons for abuse vary from person to person. In one case, the drug-dependent person has found something he knows will give him relief from tensions and anxieties which to him are unbearable. The drug is being used as an "adjustive" mechanism for living problems. It is an attempt to deal with some form of stress, conflict, or excitation.

This person's pattern of abuse may vary from infrequent sprees of intoxication to prolonged compulsive use wherein the person seeks almost *total* oblivion and may be in bed almost constantly. Other types of abusers use barbiturates in combination with other drugs, such as amphetamines or alcohol to produce an even greater mood elevation; they may be used alternately with other drugs such as alcohol, amphetamines, opiates or cocaine to relieve "coming down" effects or to alleviate withdrawal symptoms. In some cases, barbiturates may provoke stimulation and exhilaration, as can any of the depressants, in which case the drug is abused for the same reasons any other stimulant is abused.

Side Effects

Barbiturate intoxication closely resembles alcoholic intoxication, distinguished only by lack of the characteristic odor of alcohol. The effects are slurred speech, staggering gait, sluggishness; memory, judgment and comprehension are impaired. The abuser may be hostile, irritable, confused, lax in personal habits, emotionally unstable or have suicidal tendencies.

Dependence

Chronic abuse is accompanied by the development of both physical and psychological dependence. Physical dependence occurs only after prolonged use of heavy doses. Once physical dependence is established, abrupt withdrawal is extremely dangerous (far more so than with narcotics), and should always be medically supervised. Convulsions and even death can occur in unattended withdrawal.

Tolerance

With chronic abuse, tolerance builds. Dosages prescribed by a physician range from [illegible]00 mg. once or several times a day, but illicit users take as much as several thousand mg. daily.

Dangers of Abuse

With high tolerance there may well be a thin line between tolerated doses and lethal doses. Many accidental deaths occur yearly from persons miscalculating dosages due to high tolerance, use with alcohol, or poor judgment concerning "suicidal gestures." Many deliberate deaths occur since barbiturates (and recently tranquilizers) seem to be one of the preferable ways to "go."

Although initially a person may find escape from conflict in the heavy use of barbiturates, ultimately barbiturate dependency would seem to bring far more grief than it could ever dispel. The original problem remains, compounded by a preoccupation with drug-taking, loss of motor functioning, emotional stability, and interpersonal relationships. The person may endanger himself and others with his proneness to accidents and his antagonistic behavior.

Tranquilizers:

Unlike barbiturate-type sedatives, tranquilizers can be used to counteract tension and anxiety without producing sleep or significantly impairing mental and physical function.

Medical Use

Tranquilizers may be divided into two groups -- "major" and "minor" -- based on their usefulness in severe mental disorders (psychoses). The "minor" group, for the most part, is not effective in psychotic conditions, but are used widely in the treatmentment of emotional disorders characterized by anxiety and tension. Many are useful as muscle relaxants.

Abuse

It has been found that some members of this "minor" group have been abused. Chronic abuse, involving increasingly larger daily doses, may result in the development of physical and/or psychological dependence. Symptoms during misuse and following abrupt withdrawal closely resemble those seen with barbiturates. As in barbiturate-type dependence, chronic use of high doses can result in convulsions if the drugs are suddenly withdrawn. To date, abuse of tranquilizers has not become a "street" problem. Abuse supplies usually are obtained by having prescriptions refilled in excess of normal needs. Some brand name tranquilizers leading to dependence are Miltown, Equanil, Librium, Valium and Serax. The non-barbiturate sedatives are Doriden, Placidyl, Valmid and Noludar.

Dr. David Smith, a pharmacologist from the University of California Medical Center, San Francisco, does not distinguish between the so-called "minor tranquilizers" and the sedative-hypnotic drugs such as the barbiturates and alcohol in terms of their dependency-producing qualities. He feels that labeling a group of drugs "minor tranquilizers" left the impression that they were somehow "safer" to use. Dr. Smith says that sound medical practice prescribes tranquilizers as anti-psychotic drugs and sedatives as relief from acute anxiety. He has seen many patients who are dependent on the so-called "minor tranquilizers."

4. STIMULANTS

Stimulants that directly stimulate the central nervous system include caffeine, the amphetamines, and cocaine.

Caffeine, found in coffee, tea, and colas, has relatively mild effects, is considered socially acceptable, and not an abuse problem.

The amphetamines are more potent and are controlled under dangerous drugs because of their abuse potential.

Cocaine is a dangerous stimulant. International measures have been taken to reduce its abuse, and it is legally controlled in the United States by the Federal Bureau of Narcotics.

Amphetamines:

Amphetamine is a synthetic stimulant chemically related to adrenalin and ephedrine. These drugs, known as sympathomimetics, produce effects resembling those resulting from stimulation of the sympathetic nervous system, the primary control center of bodily functions. In addition to the above properties, amphetamine (Benzedrine) and related drugs such as Dexedrine and Methedrine are particularly effective central nervous system stimulants. Brand names for other amphetamine-type drugs include Desyphed, Dexamyl, and Tuamine.

Medical Use

Amphetamines are used extensively in medicine for the treatment of narcolepsy (inability to stay awake), epilepsy, Parkinsonism, certain behavior disorders in children, drug addiction, and particularly depression and obesity.

Reasons for Abuse

One factor is its appealing ability to increase alertness, dispel depression and fatigue, produce feelings of euphoria, elation and self-confidence ... all central nervous system effects. The motivation for and expectations of amphetamine effects are in sharp contrast to those of the other drugs. While, generally speaking, a relaxing, introspective or escapist state is sought from depressants, LSD or marijuana, the amphetamines produce a very much action-oriented mood, resulting in energetic tension, loud egotism, and an intense involvement in achieving tasks. It may also appreciably reduce sensitivity to the feelings of others.

Amphetamine is usually taken orally in pill or capsule form. However, pills dissolved in water and injected intravenously is becoming a common practice among certain abusers and experimenters. Methamphetamine, already in liquid form and more concentrated, is preferred by heavy users. Effects, through intravenous injections, are felt almost immediately ... hence, the term "speed" or "speeding." "Speed freaks" emphasize that their objective for shooting speed is the "flash" or orgasmic feeling, and that the euphoria is a secondary condition.

Speed "Runs"

One type of abuse by our youth is the use of "speed" in a sort of mad marathon or endurance test. During early phases the drug is injected 3 to 4 times daily. As tolerance develops, dose and frequency increases. "Runs" may last up to 12 days with the drug being taken every two hours. There is little or no food intake or sleep during these runs, as swallowing becomes very difficult. Toxic symptoms such as chest pains, severe tremors, muscle and joint pains are warnings to terminate the run. Following a long period of sleep and restoration of appetite, the abuser may "lay off" to rest and regain weight loss or he may begin another "run."

Effects of Abuse

Physical effects at therapeutic levels generally begin with increased blood pressure, dilation of the pupils, dryness of the mouth, mild gastrointestinal disturbances, rapid heart beat, restlessness, insomnia, and loss of appetite.

With increased doses or individual sensitivity, side effects may progress to talkativeness, agitation, confusion, anxiety, pallor, flushing of the skin and perspiring. Larger doses produce marked euphoria and exaggerated cheerfulness, slurred and rapid speech, tremors in the hands, urinary frequency, anxiety, tension, irritability, and a tendency to rub the nose and lick the lips. An acute psychotic episode may occur with intravenous use, or drug psychosis may develop with chronic use of large doses. Symptoms include hyperactivity, hallucinations and paranoia (feelings of persecution). The user may become very aggressive. This mental state usually disappears in three days to several weeks after withdrawal from the drug.

Tolerance

Tolerance does develop (rapidly with intravenous use) and permits the use of many times the therapeutic dose. The toxic does of amphetamines varies widely. Acute toxic effects may occur in individuals with sensitivity to the drug with doses as small as 2 mg. Some persons who have built a tolerance have been known to take 25 pills at one time and a hundred in one day. "Speed freaks" may "shoot" 400 to 1800 mg. Amphetamines are manufactured in strengths of 5, 10, and 15 mgs.

Dependence

Because there is no characteristic syndrome upon abrupt withdrawal from the drug, current evidence does not indicate physical dependency. However, dramatic after-effects may occur. Fatigue, lethargy, depression, semi-comatose sleep for several days, and ravenous appetite. These after-effects seem merely to be an all-out attempt by the body to restore itself to a normal state after the period of deprivation.

Psychological dependence is common and is an important factor in continuance of and relapse to amphetamine abuse. Where high tolerance has developed, a desire to avoid the after effects of depression encourages continued use. The repeated occurrence of whatever needs prompts use of the drug in the first place naturally prompts continued use. The truck driver is on another cross-country haul and needs to stay awake; the overworked doctor or business executive continually needs to be efficient; the housewife needs energy and optimism to last out each day; the student occasionally or often needs more studying time; the athlete his prowess at each meet; the youngsters their thrills, kicks, and lifts; and the boy whose circumstances and self-image say he's nobody needs desperately to feel "ten feet tall."

While common sense cannot condone this misuse or ignore the physical hazards involved, it cannot fail to realize why dependent people will not easily relinquish use of this chemical happiness, energy and perpetual motion. One seventeen-year-old girl who was being encouraged to give up her speed habit said, "Without speed I feel so lousy that I'd rather shoot speed and live for one week than live 40 years without it!"

Dangers of Abuse

Amphetamines seldom cause death, even in acute overdose. However, the use of "pep" pills eliminates nature's warning that a person is overexerting, masking feelings of fatigue and hunger. When endurance runs out, sudden collapse may follow. Drivers and operators of machines may be awake, but accident potential may be high because of impaired judgement. Self-neglect and aggressive behavior carry obvious implications of danger for our youthful indulgers. The high degree of aggressiveness associated with amphetamine abuse is no better exemplified than in the present situation in Haight-Ashbury where the "speed freak" has driven out the passive, peace-loving "acid head."

Miscellaneous Stimulants:

There are a number of other drugs which act as stimulants and have effects and uses similar to the amphetamines. They include Ritalin, Preludin (phenmetrazine), and Tenuate or Tepanil. To date, only phenmetrazine has been placed under the same dangerous drug controls as the amphetamines.

Cocaine:

Cocaine is obtained from the leaves of the coca bush found in the South American countries of Bolivia, Brazil and Peru. Coca should not be confused with cocoa, the name of a tree which is the source of cocoa and chocolate. Cocaine is an odorless, white crstalline powder with a bitter taste, producing numbness of the tongue. It is often referred to as "C" or "snow."

Medical Use

Cocaine was once widely used as a local anesthetic, but has been replaced by less toxic drugs.

The stimulant effect of cocaine is intense, resulting in excitability, talkativeness, a reduction in the feeling of fatigue, a sense of euphoria, increased muscular strength and mental capacity. The user may greatly overestimate his capacities. Cocaine dilates the pupils and increases heartbeat and blood pressure.

Cocaine is either sniffed or injected directly into the vein. The intense stimulatory effects usually result in the abuser voluntarily seeking sedation. This need for sedation has given rise to a practice of combining a depressant drug such as heroin with a drug such as cocaine ("speedball") or alternating a drug such as cocaine with a depressant. In some persons cocaine produces violent behavior. On long term use, the individual may be extremely aggressive and develop a disturbed mental state similar to amphetamines. Paranoia and hallucinations may occur. The user may carry weapons to use upon persecutors.

In overdose, cocaine may so depress respiratory and heart function that death results.

Cocaine does not produce physical dependence, and since apparently tolerance does not develop, abusers seldom increase their customary dose. Withdrawal symptoms do not occur, but depression and hallucinations may persist for a long time. Strong psychological dependence develops from a desire to re-experience the intense stimulations.

5. PSYCHEDELICS OR HALLUCINOGENS

Although man has sought out and used many things in the course of history in an attempt to see his world through rose-colored glasses, LSD and its successors (now coming at an increasingly rapid rate) are our current concern with mind-altering drugs. In 1965, after widespread, almost seductive publicity, a tremendous upsurge of self-administered and illicit use occurred, and was promptly followed by a tremendous number of reports of horrendous effects from the drug. This, in turn, was followed by panic. The only legitimate manufacturer in the United States ceased to produce LSD, virtually all authentic research stopped, and along with it our only hope of finding its vital and unique uses and our only means of settling once and for all the now interminable sparring match between opponents and proponents of the drug ... for we are at a 50-50 draw, and LSD and its step-children are all on the black market.

The psychedelics or hallucinogens (which rarely cause actual hallucinations) include the following:

LSD:

(D-lysergic acid diethylamide) derived from ergot, a fungus which grows on rye. It may be considered here as a gauge for the potency of and as a model for qualitative effects of the other psychedelics except for marijuana. It is highly potent ... normal dosage 100 to 250 micrograms (mcg), which amount may be lifted on the head of a pin. It is usually ingested on a cracker or sugar cube; effects take place in about 30 minutes, and last 8 to 10 hours. There is no test for detection in the body after ingestion, and it is virtually impossible to enforce laws of sale and possession since the small quantities involved are often undetectable. A quantity of LSD the size of an aspirin is sufficient to "trip out" 3000 people! Because of these "speck-size" doses, users have little chance of knowing the quality and dosage of their supplies.

Morning Glory Seeds:

Morning glory seeds contain lysergic acid amide; 50 to 300 seeds are ingested along with black, strong tea to settle the stomach, about 1/10 as powerful as LSD. Effects last 2 to 6 hours.

Peyote:

(Phenyl-ethyl-amine) of which the active ingredient is Mescaline. Buttons from the peyote cactus are brewed with tea. The tea alone may be drunk or the cooked buttons chewed along with it. Many liquids may be used to avoid the bitter taste, nausea and gagging which may occur, about 1/5000 as strong as LSD. Effects last 2 to 6 hours. Mescaline may be obtained in crystalline form. Peyote has long been used by Indians in the Southwestern United States for religious purposes, for which they have legal sanction.

STP:

Another phenyl-ethyl-amine derivative (nicknamed Serenity-Tranquility-Peace). An amphetamine and mescaline derivative with very immediate and intense effect on the brain. "Trips" may last 24 hours to 3 days. Behavioral effects are those of LSD but physical effects are greater with a scopolamine-type toxicity. Anxiety reactions are more common due to the wearing duration of the experience.

Psylocybin:

(Tryptamine derivatives) commonly referred to as the Magic Mushroom. Again taken orally with tea to settle the stomach. Effects last 4 to 6 hours. About 1/200 as powerful as LSD. Abuse is not now prevalent nor is the source great.

DET, DMT, DPT:

(De-ethyl, di-methyl, and de-phenyl tryptamine) crystals or oily liquid may be smoked with parsley leaves or taken I.V. (intravenously). Does not work orally. DMT, when smoked, lasts 15 to 30 minutes and is known as the "businessman's special." DET taken I.V. lasts 1 to 2 hours.

MDA:

(Methylenedioxyamphetamine) for the first 6 to 8 hours after ingestion, effects are qualitatively the same as LSD. The amphetamine-like effects persist longer and euphoria may be experienced, rather than depression, which frequently occurs coming down from LSD.

Nutmeg and the Asthmador Cigarette:

Considered hallucinogenic drugs (see Miscellaneous Compounds of Abuse). Banana peels or "Mellow Yellow" and 68-concentrated peppermint oil are alleged hallucinogens, but the FDA believes this to be hysterical behavior on the part of the users.

Marijuana:

(Cannabis sativa) - except for legal classification, considered a hallucinogen. Since marijuana is legally classed as a narcotic, and since it has become the youth's "drug of choice," it will be discussed separately, following the LSD material.

The lure and mystique of a mind-expanding experience with promises of internal exploration, a merging with nature, powerful insight, feelings of intimacy, brotherhood and love, a revealing significance in small things, glimpses of and a feeling of oneness with God, fantastic perceptual experience, and increased capacity for the educational, religious, ecstatic, sexual and creative aspects of life is doubtless intriguing to us all, even if resistible. Some are willing to take a crack at it a few times for kicks. Others find it the vehicle for rejecting our social standards and idealizing themselves into a crusade for changing this society into one of love, brotherhood and non-violence.

Psychedelic or Psychological Effects

Physical effects accompanying the "trip" are minimal. The psychological and sensory effects are profound and dramatic. Taste, smell, hearing and touch become more acute. Vision is affected the most; objects may shift, become wavy or appear to melt; textures become fascinating. Dream-like sequences or fantasies related to previous life experiences may be pleasant or horrible. Color may be felt as an emotion or mood, and music may be seen. This is known as synesthesia. It is speculated that the psychedelics allow more than a normal flood of stimuli into the brain -- the overflow must then be handled by one of the other senses.

Extreme swings of mood may result in a gamut of emotions during the "trip." Recall of the drug experience is often very vivid. Persons can function quite efficiently if they must (pupil dilation is often the only external sign); but usually there are lack of concentration, a rapid flight of ideas, and logic and causal relationship distortion, which account for some of the irrational behavior under the drug. Time may be distorted and confused. Depersonalization gives the user the feeling his mind is not in his body or that parts of his body are missing or do not belong to him. Above are psychological effects, clinically described. Below is a psychological interpretation experienced by R. Gordon Wasson, reported in the Botanical Museum Leaflets, Harvard University, 1961, 19 (7):

> "As your body lies there in its sleeping bag, your soul is free, loses all sense of time, alert as it never was before, living an eternity in a night, seeing infinity in a grain of sand. What you have seen and heard is cut as with a burn in your memory, never to be effeced. At last you know what the inevitable is and what ectasy means."

Psychological Side Effects

These drugs create both chronic and acute side effects, and their occurrence cannot be predicted. Some of the worst reactions have been in people who appeared most stable. Others with severe psychiatric problems seem to tolerate LSD with no ill effects.

Chronic Effects

A dramatic shift in value systems may occur after use as well as before ... users may leave families, are not interested in working or playing "ego games" of society. This decrease in aggressiveness, competitiveness, and goal of striving is usually interpreted medically in terms of avoidance, passivity, or even brain damage. Among "hippies", These qualities are sought after, and are socially reinforced as valuable to both the individual and society. One sad effect is a perceptual distortion wherein a subjective feeling of improvement is actually concomitant with an objective loss of functioning. An architect may feel LSD has brought him to the heights of efficacy and divine inspiration, when in fact, he may no longer be able to hold a job because his work is unintelligible. The ability to love and have psychic intimacy with other persons may be hampered severely because a user tends to become more introspective and invested in himself. Typically, "acid heads" become very missionary about converting other people to the use of LSD ... and will give away or share supplies to allow others to "benefit" from its use. Another chronic effect is the "flashback" (see Jargon), which may occur a day or up to a year later and may be good or bad in experience as well as occurring at an inappropriate time.

Acute Effects

Four major types of acute symptoms have been seen. These include -- in decreasing frequency -- hallucinations, anxiety to the point of panic, severe depression with suicidal thoughts or attempts, and confusion. These symptoms may occur in patients who have taken LSD once, or 60 times; they may occur in multiple drug users or in those taking only LSD. "Bad trips" and acute reactions may occur under the most ideal conditions of set, setting, guide, and preparations. However, it should be noted particularly that the frequency of bad trips and psychotic reactions are percentage-wise very rare. Some people recover in a matter of days, some "blow their minds" for good. Those hospitalized for acute reactions often go right back to "dropping acid" once released.

Dependence and Tolerance

The preceding remark is a good indication that for many people the psychedelics induce a strong psychological dependence. Tolerance, at least for the psychological effects of the trip, develops so rapidly users generally take acid only once or twice a week. Physical dependence does not seem evident.

Physiological Effects

Despite the chronic personality and behavioral changes, organic brain damage has not yet been demonstrated in humans as it has in animals.

Chromosome fracturing in the white blood cells of humans, which can be directly accountable to LSD usage, has been observed, but the vastness and seriousness of the implications is debatable and awaits further studies. Until more is known about their long and short term effects, these highly potent and effective drugs must be considered dangerous.

Dangers of Abuse

Impulsive behavior such as "joining the sea," "merging with traffic," and taking unscheduled flights from third story windows -- plus resultant suicidal tendencies found in psychotic reactions represent enough of a danger in themselves though they occur infrequently. What does occur from day to day is the usual self-neglect accompanying all heavy drug preoccupation and the impending danger of impurities in supplies. And of even more concern ... the fact that the use of psychedelics has descended the ladder into high school and junior high school age groups ... an age more loaded with conflict than any other. Every vital resource is needed to help drug users resolve these conflicts constructively and permanently rather than to be side-tracked by a panacea substitute for life goals.

6. MARIJUANA (CANNABIS)

Historically, cannabis has been known as a remedy since 1000 B.C. Its euphoriant powers have been noted since 650 B.C. For 3000 years man has regarded cannabis as the best of all possible goods, the worst of all evils; he has used it to cure and to relieve pain, as a vital fiber crop, for devious profit, as a cause of prosecution, and as a source of escape and enlightenment. Cannabis has brought much pleasure and much sorrow to the world. Little is known about it. A great deal has been said.

Description

Cannabis indica, Cannabis sativa, Cannabis americanus, Indian hemp, and marijuana (marihuana) all refer to the same plant. One active ingrediant of cannabis, found primarily in the flowering tops of the female plant, has been identified as tetrahydrocannabinol (THC). Eighty derivatives of THC are being isolated and studied; stable forms of this agent will permit more accurate research into long and short term effects by allowing standardized doses, the lack of which has hindered studies to date.

Cannabis grows wild in temperate climates throughout most of the world, supported on the poorest of soils. Potency is determined by location, cultivation, prevention of pollenation, and means of preparation. The following forms and modes of use are some of those found in Eastern countries, the United States, Mexico, and Latin America.

charas (Indian) - unadulterated resin from specially cultivated Cannabis sativa; is most potent form; usually smoked.

ganja (Indian) - tops and some resin of female Cannabis sativa; used in confections and beverages, but usually smoked.

Bhang (Indian) - cheap, low in potency, usually used as a drink.

hashish (Middle East) - when term is used correctly it refers to a powdered and sifted form of charas; is used widely to refer to any form of Cannabis.

kif - cannabis preparation used in Morrocco.

dagga - cannabis preparation used in South Africa.

marijuana - mostly dried leaves and flowers; one-fifth to one-eighth as potent as charas or hashish. Referred to as grass, rope, hay, hemp, jive, Mary Jane, pot, Texas tea; usually smoked with or without tobacco as a cigarette (reefer); may be ingested (often with sweets) or sniffed.

Classification

Marijuana is legally classified as a narcotic; pharmacologically, it is most often considered an hallucinogen, although it should be noted hallucinatory effects do not usually occur except with high potency doses. Marijuana has often been described as a mild euphoriant in weak forms, a powerful hallucinogen in strong forms. Attempts have been made to classify marijuana as a sedative-hypnotic, which would allow a closer comparison of its effects to those of alcohol and the barbiturates.

Medical Uses

"Medicine in the Western world has forgotten almost all it once knew about therapeutic properties of marijuana, or cannabis ... "recreational" smoking of cannabis in the twentieth century and the resultant restrictive federal legislation have functionally ended all medical uses of marijuana ... in the light of such assets as minimal toxicity, no build up of tolerance, no physical dependence and minimal autonomic disturbance, immediate major clinical re-investigation of cannabis preparations is indicated in the management of pain, chronic neurologic disease, convulsive disorders, migraine headache, anorexia (loss of appetite), mental illness, and bacterial infections ..."*

---

*Mikuriya, Tod H., M.D. MARIJUANA IN MEDICINE: PAST, PRESENT AND FUTURE (presented before the Second General Meeting at the 97th Annual Meeting of the California Medical Assn., San Francisco, March 23 to 27, 1968).

The opposing and most widely-held opinion today, of course, is that science and medicine have simply outgrown the use of marijuana as a therapeutic agent ... that more satisfactory and effective pharmaceuticals have replaced marijuana.

Psychological Effects

Determinants

"The effects of marijuana, even more than those of many drugs, are variable in different individuals and in the same individual at different times. The subjective effects are exquisitely dependent, not only on the personality of the user but also on the dose, the route of administration, and the specific circumstances in which the drug is used. The effects are also a function of learning to smoke properly, of being tutored in recognizing and labeling effects, and of becoming sensitized to the effects."*

By controlling time and amount (titration), experienced marijuana users are able to sustain and regulate their "high" at a desired level of effect with far more accuracy than persons using alcohol.

Marijuana effects may be felt in a few minutes and usually last four to six hours, and occasionally twelve, depending on the dose, individual and setting.

The Marijuana "High"

Common effects have been variously described as a feeling of contentment and inner satisfaction, free play of the imagination, exhilaration of spirit, the feeling of floating above reality, ideas disconnected, uncontrollable and free-flowing, minutes seeming like hours, space broadened, near objects seeming distant, with or without depression. In some individuals and under some circumstances the depression may be the initial response and be followed by the "high." At higher dosage levels extremely vivid hallucinations may occur, with the content highly dependent on the personality of the individual. Marijuana is said to accentuate basic personality traits and predispositions (i.e., a basically sad person may become morose, an out-going person, gregarious, etc.). Marijuana is said to enhance creativity. There are as many opinions concerning this as there are artists and critics.

Adverse Psychological Effects

Anxiety and panic states can happen with any dosage level. This is usually (particularly with novices) a result of not being comfortable with the effects and an anticipation of negative consequences. At higher dose levels the possibility of anxiety states increases as well as paranoid feelings and transient psychoses. Transient psychoses may last four to six hours; incidence is very low. Toxic psychoses, which may last several days, several weeks, or several months, has been negligible in the United States, but not uncommon in U.S. servicemen in Viet Nam where very strong and potent marijuana (often still containing the seeds) is available and rather widely experimented with. It is still to be decided whether cannabis in any strength can cause irreversible psychoses. The best available information indicates that our mild U.S. form does not.

---

*Nowlis, Helen H., Ph.D., DRUGS ON THE COLLEGE CAMPUS, p. 85 (see Bibliography).

For most people, smoking marijuana is a pleasurable experience. In addition, the fact that marijuana reduces inhibitions helps explain its use principally as a social pastime and relaxant throughout our society, from middle class "straight" citizens to our "conforming" youngsters to every form and faction of "outcast" and "dropout." The danger, as with alcohol and other depressant drugs, is that marijuana may remove the last and final barrier of constraint and allow acting out of sexual urges, aggressive or criminal behavior, reckless driving practices, etc. It may also remove the last remnants of inclination for work, ambition or productivity. Here again, the degree of drug involvement and individual adjustment or lack of it will be more likely to determine specific behavior than the pharmacological effects of the drug. Peer groups may also play a vital part in the initial use, continuance of, or relapse to any drug.

Dr. Stanley Yolles, former director of the National Institute of Mental Health, discusses one of the most serious psychological hazards: "Patterns of coping with reality developed during the teenage period are significant in determining adult behavior. Persistent use of an agent which serves to ward off reality during this critical development period is likely to compromise seriously the future ability of the individual to make an adequate adjustment to a complex society."

Physical Effects

Short Term Effects

Cannabis may cause nausea and vomiting in novice users. Recent studies have confirmed reports in literature of increased pulse rate and reddening of the eyes; these studies have opened serious doubt to reported effects of increased blood pressure, blood sugar and pupil dilation. While, at certain doses, impairment of muscular coordination was substantial for novice users, psychomotor activity and muscular coordination of experienced users appeared to be unaffected or slightly improved. These findings merely point up our need to do more research, to keep an open mind, and to consider, above all, variable factors such as experience, personality, dosage, and setting.

Symptoms of urinary frequency, dryness of mouth and throat, appetite for sweets, time and space distortion, disrupted sleep patterns, and drowsiness have been reported, particularly as doses increase.

Long Term Effects

Studies conducted in India on persons using highly potent cannabis over long periods of time report a prevalence of chronic bronchitis, increased incidence of tuberculosis, redness of the eyes, various digestive ailments, and deterioration of general health. For the above, as with the high correlation between cannabis use and irreversible psychoses in India and other Eastern countries, it is hard to establish a cause and effect relationship because of the other factors involved. We have no evidence of permanent physical harm from our mild cannabis form in the United States except that which results from self neglect. However, the fact remains that marijuana smoke is irritating and until long term effect studies are conducted we have no assurance that we do not have another lung killer. Until more valid tests are run on the effects of marijuana on driving skills we have no assurance that we do not have another highway killer.

Dependency and Tolerance

There is no evidence to indicate that either a physical dependence or tolerance is established with use or abuse of marijuana. Psychological dependence may develop according to involvement. Many people use marijuana as casually and infrequently as light social drinkers use alcohol; for others, marijuana may be an important and integral part of a multi-drug abuse way of life.

7. MISCELLANEOUS COMPOUNDS OF ABUSE

General Trends in Abuse

It has been estimated that in the next few years the number of common day substances and new compounds which will be experimented with and abused will increase into the thousands of percent. The fad for experimentation has become almost an end unto itself. Youngsters buy various counter medications, mix them and put a handful into their mouths to see what will happen. Today, the "fruit salad" and a search through the pharmacology books for interesting sounding side effects ... tomorrow, what?

Tomorrow promises more of this deliberate and intense search for "pharmaceutical fantasia" unless we can convince our youngsters they must preserve their bodies and minds first, and seek suspense, anticipation, and ensuing experience secondly. Otherwise, if physical and mental faculties are irrevocably lost, the search itself and its discoveries are impossible.

The "Needle Syndrome"

An incredible abuse practice occurs when a heavy "mainliner" (one who injects drugs intravenously) transfers his dependence upon drugs to the compulsive use of the needle itself. A specific drug effect becomes less important; getting something or rather anything, into the vein is his goal. This leads to injections of deodorants, cleaning agents, peanut butter, Kool-aid, shoe polish and "anything goes." This combination of risk and compulsion has resulted in tragic deaths.

"Rushing and Milking the Rush"

Rushing is the slang term for the effect gained by injecting water into a vein -- the instant effect is the goal, as there is no prolonged "high."

"Milking the Rush" is a term which means alternately squeezing and releasing the bulb which forces the substance into a vein. It is done by heroin users to savor and prolong the effect, and by users of other substances (even ice water), especially the speed drugs for similar reasons.

Solvents, Volatile Compounds, Hydrocarbons (or Deliriants):

While there are specific differences, gross effects, methods and reasons for abuse are quite similar. Therefore, these substances will be discussed together.

Classification

The solvents include toluene (found in model and airplane glue), acetones (fingernail polish remover), esters, alcohols, and ether.

Chlorinated hydrocarbons (mostly cleaning fluids) include carbon tetrachloride (highly toxic), benzene (found in rubber cement), and naptha. Fluorinated hydrocarbons are found in freon, glass-chilling pans and frying pan spray coatings (Pam).

Gasoline is a hydrocarbon with an added hazard -- lead, which can add its own poisoning or toxic effect. Mineral oil, if excessively used can cause pneumonia.

There is abuse potential in kerosene, lighter fluid, many aerosol preparations such as hairspray and silicones, marking pencil fluid, paint and lacquer thinner, etc. Laughing gas and amylnitrite, have also been abused.

Reasons for Abuse

Glue sniffing and other practices with the volatile compounds are most prevalent in the 8 to 15 year-old age group. A "high" or eupnoria and other effects similar to alcohol intoxication are sought. These inhalants are usually put on a rag and held to the nose or put in a plastic bag (particularly glue) and the bag held close over the mouth and nose.

Effects of Abuse

The effects are not usually long lasting unless use is prolonged. Then speech becomes slurred, gait unsteady; the user may become disoriented and commit irresponsible acts.

Prolonged abuse may result in toxic psychosis or personality alteration. Physical effects of extreme abuse include respiratory depression and/or cardio-vascular collapse and asphyxia. Damage to the brain, kidney, liver and bone marrow may occur, but some authorities say that apparently this damage is reversible when use discontinues. Delirium and seizures may occur with the hydro-carbons.

Dependency

Evidence points to tolerance and psychological dependence, particularly in the case of airplane glue.

Nutmeg:

Nutmeg is used for its mind-altering or hallucinogenic effects. Three teaspons to three tablespoons of powdered nutmeg taken in a hot drink lead to hallucinations. The stimulant dosage is close to the toxicity level. Beginners usually suffer headache, nausea, dizziness, and feelings of depersonalization. Long term use may lead to liver damage.

Anticholinergic Agents:

Scopolamine, atropine, and stromonium are derived from belladonna and other natural plants.

Medical Use

As central nervous system depressants, these substances are found in "over the counter" compounds for sleeping and composing aids such as Sominex, Compoz and Sleepeze. As anti-spasmodics and secretion inhibitors, they are used medically in the treatment of ulcers, asthma, and sold "over the counter" in cold compounds such as Contac and the Asthmador cigarette.

Reasons for Abuse

Anticholinergics are abused primarily for hallucinogenic reasons, due to an additional scopolamine effect on the central nervous system. South American Indians use plants containing scopolamine and atropine in their witchcraft rites to produce "frenzy and narcosis." North American abusers look forward to an LSD type trip, or at least a euphoria or "high."

Side Effects

These drugs lead one to wonder if the trip could be worth the traveling conditions. Sweat glands, salivary and bronchial secretions dry up making one hot, dry and flushed; pupils dilate preventing focusing; hallucinations occur ... thus fostering the expression "dry as a bone, red as a beet, blind as a bat, and mad as a hatter." Even at therapeutic doses scopolamine may produce excitement, hallucinations, and delirium, whereas, in the case of atropine, doses bordering on the toxic are generally required before hallucinations and central nervous system effects are experienced. Most preparations contain 0.125 mg to 0.250 mg of scopolamine per tablet. Ten (10 mg) of scopolamine is likely to be fatal.

Patterns of Abuse

Youngsters are prone to abuse the Asthmador cigarette. They burn the agent in a bowl and inhale the fumes, or they ingest 1 to 3 teaspoons in water. Older hallucinogenic users generally resort to these substances only when preferable agents are not available.

8. PROFIT MOTIVE*

Marijuana	(Cannabis Sativa L) - One Kilo (Approximately 2.2 pounds) Sold in United States for $120.00 per Kilo. Sold in Mexico for $50.00 per Kilo. If purchased in United States in lots of fifty or more, sold for $50.00 per Kilo. One lid (Approximately 2 ounces) - $15.00 per Lid. One match box (Approximately less than 1 ounce) $5.00 each. One joint (cigarette) Approximately $ .50 each. Hashish - A concentrated derivative of Marijuana - $7.00 to $15.00 per gram. One Kilo of Marijuana will make 2,450 cigarettes (joints). A pusher will get a return of $1,225.00 for an initial investment of $50.00 to $120.00.
Heroin	Pure Heroin (85% to 95% pure) per Kilo sells for $12,500.00. When cut to 35% pure - $340.00 per ounce. Street sales in number 5 caps (about 1-1/2 grains and about 2% pure) sell for $5.00 each. Total Profit: One Kilo will produce about 319,200 caps at about $5.00 per cap, will equal about $1,000,000.00.
Cocaine	Sells for $1,400.00 per ounce when pharmaceutically pure. Retails for $50.00 a spoon (about 12 grains).
Dangerous Drugs	May be purchased on the legal market and are relatively inexpensive.

---

*All prices are approximate

LEGAL ASPECTS

VI

VI

LEGAL ASPECTS

In the opinion of most authorities who work with adolescents, it is extremely doubtful that many youngsters are deterred from drug abuse or experimentation by the threat of severe legal consequences. Appealing as this approach is to adults, it seems to have little impact on adolescents. There are several reasons for this. Adolescents, just beginning to assume an "identity" and to feel their individuality, give little thought to growing old. Indeed, for the most part adolescents convey to the older generation the idea that they expect to remain forever young and invulnerable to adult problems. In addition, there seems to be a rather general attitude on the part of adolescents that seems to proclaim, "It can't happen to me!"

Rebellion against the authority of the "establishment," including parental, school and police authority, often manifests itself in drug abuse in the student's sphere of activity. Connected to the rebellious pattern, there is also what some have called "mystique" of drug use, including the fascination some adolescents have for the criminal and furtive behavior that drug abuse requires. Its paraphernalia, the criminals who supply the drugs, the game of eluding the police, and other aspects which attract the adolescent are quite beyond adult comprehension.

These factors seem to combine and produce an attitude of denial (often expressed with great sincerity and persuasiveness) insofar as the criminal behavior aspects of drug abuse are concerned.

At least one authority in working with school students has found that youngsters were under the impression that the fact of their being juvenile was a defense against prosecution on drug charges, especially the marijuana statutes. They apparently thought that the policy of most newspapers to withhold names of juveniles arrested on drug charges meant that they were safe from prosecution. Certainly juveniles should be made aware of the falsity of these impressions.

Regardless of how we feel about the laws and potential punishment that a youngster faces for violation, we should make the consequences of a drug arrest vividly clear to anyone who has a false impression of the potential problems that might follow. We owe it to the adolescent to point out the fact he may be convicted of a misdemeanor which carries a penalty of a $500 fine and one year in the county jail for a first offense and that a felony conviction may result from a second conviction of the dangerous drug act. This is entirely possible to ensue from the simple situation of being arrested with a marijuana cigarette in his possession and could destroy his future educational opportunities. A felony conviction severely limits his employment future, and may result in the loss of certain civil rights. It should be made clear that a felon has a lifelong stigma on his record and that society is not ready yet to trust the convicted felon in most instances. Any thought that a marijuana charge is not as "serious" a felony as some other felonies should be corrected.

The following compilations of the current federal and state statutes on drugs were obtained from the Denver Police Department and the Jefferson County Sheriff's Department.

COLORADO REVISED STATUTES
(CRS 1963)
ARTICLE 5
NARCOTIC DRUGS

Colorado Revised Statutes 1963, Article 5, articles 48-5-1 through 48-5-21 which covers areas from unlawful to possess to federal conviction or acquittal, including regulation of license, sale, professional use, records, labels, common nuisances, enforcement and others. This law not only specifically includes Coco leaves or derivatives, Opium or any derivative, as well as others, naming Cannabis Sativa L. in any form, from seeds or preparation, excluding sterilized seed.

Violations of this article vary from felony to misdemeanor. Whoever violates sections pertaining to license, growing or processing and legal possession, also records, labels, fraud, shall be guilty of a felony and may be fined not more than $10,000 and imprisoned not less than one nor more than five years at the first offense. The second offense is the same fine but not less than two nor more than ten years. A third offense is not less than five nor more than twenty years, the fine remaining the same.

Felonies also include unlawful possession and common nuisances, the latter being any store, shop, house, building, vehicle, etc., used for the illegal keeping, selling or storing of narcotic drugs or such place that is resorted to by narcotics addicts. The fine again is ten thousand dollars, not less than two years nor more than fifteen years in the State Penitentiary for the first offense. The second offense has the same fine but not less than five nor more than twenty years. For a third offense the fine is still ten thousand dollars, however, the sentence is not less than ten nor more than thirty years.

The more severe of the penalties is reserved for section 48-5-20, (1) (a). A person with intent to induce or aid another to unlawfully use or possess narcotic drugs, possess for sale, sell a narcotic drug, induce or attempt to induce any person to unlawfully use or administer any narcotic drug, is guilty of a felony crime.

Upon conviction of subsection (1), the subject may be sentenced to the State Penitentiary for not less than ten years nor more than twenty years for the first offense. A second offense is punishable by not less than fifteen years nor more than thirty years. Any subsequent conviction will be punished by not less than twenty years nor more than forty years. Under certain conditions, the minimum sentence must be served.

If that person induced is under twenty-five years of age at the time of violation, the violator shall be imprisoned for life. For a second conviction a death sentence is possible.

Any person addicted to the use of narcotic drugs or use narcotics or are under the influence is a disorderly person, a misdemeanor, and may be confined to the county jail for not less than six months nor more than one year.

These laws are severe, but so is the damage to our society.

NARCOTICS AND THE JUVENILE

The child under the age of eighteen years faces a completely different situation when abusing drugs than he does when possessing narcotics. Not only are the laws enforced differently but environment in social strata differs and most important the child is on the threshold of a new and damaging experience that if continued will lead to total self destruction.

The possession of marijuana is a felony crime under both the Federal and Colorado statutes. A first offense of possession of any dangerous drug is a misdemeanor. The child (except those under fourteen years of age) may be charged with a felony crime and tried in Juvenile District Court. However, the disposition does rest with this court.

When arrested, the child will be held in detention until released to parents or legal guardian, either by arresting officer or Juvenile Court depending upon situation and disposition of all persons concerned.

The child may be held to be either a child in need of supervision or a delinquent child. When any action is taken, the welfare of the child is the most prominent concern to all.

Dangerous drugs should not be confused with narcotics, as they are separate offenses. The possession of marijuana is a felony. Possession of a drug (for instance LSD$^{\underline{25}}$) is a misdemeanor.

The child, once introduced to narcotics may develop a completely new peer group, changing his values and rebelling against the "straight" or non-narcotic way of life. To be "busted" (arrested) may become his newest status builder and enhance that child's position in his particular sub-culture and/or peer group. This is not true with all or even most young people. To be arrested for many and to realize this is no game may well straighten the behavior of the average child.

FEDERAL AND STATE STATUTES ON DRUGS

Peyote

State	Federal
1st offense $100-300 and/or 30 days to 6 mos. 2nd offense 1-3 years.	See Dangerous Drug Law Violations.

Dangerous Drug Law violations (amphetamines, barbiturates & hallucinogens)

State	Federal
1st offense for use or possession is up to 1 yr. 2nd offense is up to 2 yr. and/or $1000. 3rd offense is a felony (1-14 yrs.) and/or $2000. For sale or manufacture 1st offense is 1-14 yrs. and/or $1000. 2nd offense is 5-30 yrs. and/or $5000.	For 1st or 2nd offense on possession, 1 yr. or $1000. For 3rd offense possession 3 yrs. and/or $10,000. For sale, manufacture or delivery 5 yrs. and/or $10,000. For sale to minor under 21, 1st offense is 10 yrs. and/or $15,000. 2nd offense is 15 yrs. and/or $20,000.

Narcotic Law Violations (opium derivatives - heroin, morphine, etc.) and marijuana

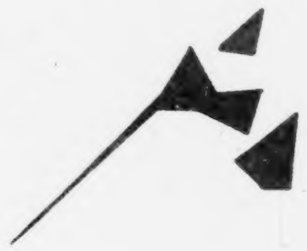
State	Federal
1st time for possession is $10,000 and/or 2-15 yrs. 2nd time is $10,000 and/or 5-20 yrs. 3rd time is $10,000 and/or 10-30 yrs. For sale 1st time is 10-20 yrs., 2nd time is 15-30 yrs., and 3rd time is 20-40 yrs. (No parole until minimum time is served.) For sale to a person 25 or under, 1st time is life, and 2nd time is life or death. For attempting to steal narcotics, 1st is 2-15, 2nd time is 5-20, and 3rd is 10-40 yrs. Being under the influence of a narcotic is punishable by 6 mos. to 1 yr. in the County Jail.	For possession of marijuana only on the 1st offense the judge may grant probation. Otherwise the 1st offense is $20,000 and/or 2-10 yrs. 2nd offense is $20,000 and/or 5-20 yrs. 3rd offense is $20,000 and/or 10-40 yrs. For sale, the first offense is 5-20 yrs. and/or $20,000. 2nd offense is 10-40 yrs. and/or $20,000. The minimum sentence must be served on convictions for selling. For sale to a person under 18, the penalty is 10-40 yrs. plus a $20,000 fine. For selling heroin to a minor, the death penalty can be involked.

Using a motor vehicle to transport or conceal narcotics is a federal offense, and such vehicle is forfeit to the government. The government seizes an average of 3 cars per week in Denver under this law.

Under the Marijuana Tax Act of 1937, there is a $100 per ounce tax on the transfer of marijuana. As a hypothetical case, suppose someone sells a kilo (2.2 lbs.) of marijuana illegally. He would owe the Bureau of Internal Revenue $3800 in taxes. If caught and convicted, not only would he receive a jail sentence, but Internal Revenue could attach any property of value in order to collect the tax.

PROBLEMS OF ABUSER IDENTIFICATION AND REFERRAL

VII



VII

PROBLEMS OF ABUSER IDENTIFICATION AND REFERRAL

Much has been written on the "symptoms of drug abuse," and on the manifestations of specific drugs. We recommend a careful reading of Part V, "Problems of Abuser Identification," in Drug Abuse: Escape to Nowhere (see Bibliography), which we consider the best material available on the subject. Too many fear reactions have resulted in an over-detailing of symptoms, to the degree that perfectly normal adolescent behavior is sometimes interpreted as a sign of "drug abuse."

In addition, it is important to be alert for gross changes in student behavior, achievement, and attendance, and not to puzzle over the small variations which are a part of normal adolescent growth and development.

The procedures for handling a student abuser will vary from one school system to another, but most systems now have set policies and procedures based on current medico-legal opinion. Those who work directly with students should familiarize themselves with the policy of their system, particularly the handling of acute situations. A copy of the Colorado Department of Health publication Facilities and Resources in Colorado for Persons with Alcohol and Drug Problems is available at your local health department and can be consulted when a need for facilities arises. This publication was revised in 1970 and every effort is made to keep it up to date.

DRUG ABUSE AND MISUSE - PROBLEM OF IDENTIFICATION*

Drugs are available around elementary schools, junior and senior high schools, and on college campuses. Parents, teachers, counsellors and others involved in the lives of youth should be able to recognize the most common signs of drug abuse. Young drug users are frequently relieved to be discovered, and accept help with any underlying problems if it is offered in a constructive, non-punitive manner. The following information is being distributed in several states by groups interested in the prevention of drug abuse.

I. COMMON SIGNS OF DRUG ABUSE

*A. Poor school attendance and lower grades.
*B. Unpredictable outbreaks of temper.
*C. Moodiness.
*D. Unkempt physical appearance.
*E. Wearing sunglasses at inappropriate times (to conceal redness of eyes, constriction or dilation of pupils).
F. Wearing long-sleeved shirts or blouses constantly to hide needle marks.
G. Stealing, or borrowing frequently from other students to obtain money required to purchase drugs.
H. Appearing frequently in out-of-the-way areas such as closets, storage areas, or rest rooms.

*May occur in normal adolescence. We should not get so hooked on the drug problem that we accuse a boy or girl of drug use when their behavior is really due to a broken romance or a family argument over grades.

II. SPECIFIC SIGNS OF SOME COMMONLY ABUSED DRUGS

A. GLUE SNIFFING

1. Runny nose and watery eyes.
2. Pungent odor of substance inhaled remaining on clothes and breath.
3. Drowsiness and poor coordination.
4. Rags, plastic or paper bags containing dried glue or model cement in student's belongings.
5. Nausea, poor appetite, weight loss. (Frequent user.)

B. MARIJUANA (Pot, The Weed, Grass, Hay, Mary Jane, Hemp. Smoked rolled in cigarette paper (reefers, joints, sticks), or in Oriental-style water pipe).

1. Red, watery eyes.
2. Hilarity, talkativeness and general animation in the early stages.
3. Later, uncoordination and drowsiness.
4. Impaired sense of time and distance.
5. Unrealistic evaluation of own brilliance and creativity.

C. STIMULANTS (Amphetamines, Bennies, Speed, Crystal, Pep Pills).

1. Excessive activity; difficulty sitting still.
2. Euphoria, liveliness, talkativeness; followed by depressed mood and irritability.
3. Tremor; unsteady hands.
4. Dilated pupils.
5. Dryness of mouth and nose.
6. Flushing, excessive sweating.
7. Exaggerated self-confidence.
8. Prolonged periods without eating or sleeping. (Frequent user.)

D. HALLUCINOGENS (Most commonly at present -- LSD, "Acid".)

1. Dream-like trance.
2. Increased heart rate, dilated pupils, "goose-bumps".
3. Inappropriate sense of time.
4. May experience fear, terror, grotesque distortion of visual and auditory stimuli and self-image ("bad trip").
5. In contrast to other drug users, may be anxious to relate experiences and "insights", less apt to hide their involvement. Authority figures can't count on this.

E. NARCOTICS (Heroin, Morphine, Demerol, Codeine).

1. Needle marks over veins of the arm ("mainlining"), or over other parts of the body.
2. Constricted pupils which don't respond to light.
3. Lethargy, drowsiness.
4. Syringes, needles, bent spoons hidden in student's locker.

F. DEPRESSANTS (Barbiturates, "Goofballs". Other sedatives).

1. Signs similar to alcoholic intoxication without the odor of alcohol.
2. Drowsiness or sleeping in class.
3. Unsteady, stumbling gait.
4. Slurred speech.
5. Loss of interest in usual activities. (Frequent user.)

---

* Prepared by Colorado Chapter of the American Academy of Pediatrics

COMMON SYMPTOMS OF DRUG ABUSE

Note: The following material is a summarization of Part V, "Problems of Abuser Identification," in Drug Abuse: Escape to Nowhere.

Not all drug abuse-related character changes appear detrimental, at least in the initial stages. For example, a usually bored, sleepy student may -- while using amphetamine -- be more alert and thereby improve performance. A nervous, high-strung individual may, on barbiturates, be more cooperative and easier to manage.

What teachers must look for, consequently, are not simply changes for the worse, but any sudden changes in behavior out of character with a student's previous conduct. When such behavioral expressions become "usual" for an individual, there is a causal factor. That factor may be drug abuse.

Signs which may suggest drug abuse include sudden and dramatic changes in attendance, discipline and academic performance. With the latter, significant changes in legibility, neatness, and caliber of homework may be observed. Drug abusers may also display unusual degrees of activity or inactivity, as well as sudden and irrational flare-ups involving strong emotion or temper. Significant changes for the worse in personal appearance may be cause for concern, for very often a drug abuser becomes indifferent to his appearance and health habits.

In addition to these behavioral clues, which are common to most drug abusers, each form of abuse generally has specific manifestations that help identify those engaged in it. They are as follows:

The Glue Sniffer

The glue or solvent sniffer usually retains the odor of the substance he is inhaling on his breath and clothes. Irritation of the mucous membranes in the mouth and nose may result in excessive nasal secretions. Redness and watering of the eyes are commonly observed. The user may appear intoxicated or lack muscular control, and may complain of double vision, ringing in the ears, vivid dreams and even hallucinations. Drowsiness, stupor and unconsciousness may follow excessive use of the substances.

Discovery of plastic or paper bags and rags or handkerchiefs containing dried plastic cement is a telltale sign that glue-sniffing is being practiced.

The Depressant Abuser

The abuser of a depressant drug, such as the barbiturates and certain tranquilizers, exhibits most of the symptoms of alcohol intoxication with one important exception: there is no odor of alcohol on his breath. Students taking depressants may stagger or stumble in classrooms and halls. The depressant abuser frequently falls into a deep sleep in the classroom. In general, the depressant abuser lacks interest in activity, is drowsy, and may appear to be disoriented.

The Stimulant Abuser

The behavior of the abuser of stimulants, such as amphetamine and related drugs, is characterized by excessive activity. The stimulant abuser is irritable, argumentative, appears extremely nervous and has difficulty sitting still in the classroom. In some cases, the pupils of his eyes will be dilated even in a brightly lit place.

The Narcotic Abuser

Few narcotic abusers are seen in school situations because they usually cannot function within the ordered confines of such institutions. However, some individuals begin narcotic abuse while still attending school. Such individuals are likely to be drinking paregoric or cough medicines containing narcotics. The presence of such bottles in wastebaskets or around school grounds is a clue to this form of abuse. The medicinal odor of these preparations is often detectable on the breath.

The Marihuana User

While marihuana is pharmacologically a hallucinogen, its widespread use warrants separate discussion. The user of marihuana ("pot") is unlikely to be recognized in the classroom unless he is heavily under the influence at that time. In the early stages of the drug effect, when the drug acts as a stimulant, the user may be very animated and appear almost hysterical. Loud and rapid talking with great bursts of laughter are common at this stage. In the later stages of the drug effect, the user may seem in a stupor or sleepy.

Marihuana smokers may also be identified by their possession of such cigarettes, often called "sticks," "reefers" or "joints." A marihuana cigarette is often rolled in a double thickness of brownish or off-white cigarette paper. Smaller than a regular cigarette, with the paper twisted or tucked in on both ends, the marihuana cigarette often contains seeds and stems and is greener in color than regular tobacco.

The Hallucinogen Abuser

It is highly unlikely that students who use hallucinogenic drugs (such as LSD) will do so in a school setting. Such drugs are usually used in a group situation under special conditions designed to enhance their effect. Persons under the influence of hallucinogens usually sit or recline quietly in a dream- or trance-like state. However, the effect of such drugs is not always euphoric. On occasion, users become fearful and experience a degree of terror which may cause them to attempt to escape from the group.

Hallucinogenic drugs are usually taken orally. Although sometimes found in tablet or capsule form, they are most commonly seen as liquids. Users usually put drops of the liquid in beverages, on sugar cubes, crackers, or even on small paper wads or cloth.

Identification of Drugs

A frequently asked question is: How can I identify "abuse" drugs? How can I tell them from legitimate prescription medicines?

The answer is that no one can effectively identify a drug by sight, taste or smell. For one reason, all the drugs discussed, except for marihuana, can be found in tablet, capsule, powder and liquid form -- and in varying colors and shapes. Even marihuana, which is usually smoked, can be found as a candy. Marihuana cookies and marihuana tea also exist.

The only way, therefore, that most drugs can be correctly identified is through a series of complicated laboratory procedures performed by trained technicians. The best a teacher can do is to suspect the possibility of abuse when drugs are found under peculiar circumstances or in the possession of someone exhibiting unusual behavior.

What To Do

The proper handling of drug abuse situations is of vital concern to classroom teachers, guidance and health personnel, and administrators. Educators often ask, "What do we do if a student appears to be abusing drugs?" There is no easy answer to this question, due to the inherent complexity of drug abuse--including the fundamental difficulty of being certain that drug abuse even exists. Additionally, educators must be concerned with the roles they play even after a suspicion is confirmed.

This can involve ongoing counseling with parents, help with the student's rehabilitation, continuing rapport with law enforcement agencies, and a need to determine if more than one student is affected. Although the responsibilities of school personnel in these areas will vary from school to school, and therefore cannot be individually delineated here, everyone concerned with education should be familiar with the broad concepts of action in drug abuse situations.

Unusual, but most critical, is the emergency situation. In a case of unconsciousness, which may be drug-induced, rapid aid is vitally important. Most schools have a standing procedure for emergencies. But where none exists, a doctor should be called immediately or an ambulance should be summoned to take the victim to a hospital. If breathing fails, some form of artificial respiration should be administered until medical help arrives. Naturally, parents should be advised of the situation as quickly as possible.

CONCLUSION: Where do we go from here?

VIII

CONCLUSION

Where Do We Go From Here?

After a lengthy and thorough study of that portion of the drug abuse problem which pertains directly to youth and drugs, it is our conviction that maximum effort should be concentrated in attempting to achieve the following objectives:

I. Every community, through its duly elected boards of education, should begin at once to write and adopt a full health education course of study to be integrated into existing curricula. Resources and consultants should be employed from our medical centers, colleges and universities, Departments of Education and Health, the School Health Advisory Committee, local school personnel, and all others knowledgeable in the field of health education. The health education course should be totally comprehensive, preferably K-12, and include meaningful education in all areas of personal living not just alcohol and drugs. It is not within the professional scope of the Alcoholism and Drug Dependence Division of the Department of Health to recommend the specific content or grade-levels of material of such a course, but experience has shown that until such a course is taught we will continue to offer fragmented education on demand in such areas as sex education, venereal disease education, and drug abuse education (including alcohol and tobacco). The intent of a well-integrated course in living education, taught as naturally and given as much importance as any other required course, should be to produce citizens who are aware of the dangers of substance abuse, have respect for medically prescribed drugs and know of the risks involved in using alcohol, tobacco and other legal drugs, as well as the dangerous implications of illicit drug use.

Only when such a course is taught in every school district throughout the state can we dispense forever with "one-shot" methods of bringing in outside experts in the various areas mentioned, methods which historically have failed in modifying attitudes and behavior and in too many cases may have been actually harmful to an undeterminable number of our young people. The drug abuse problem is especially amenable to this total curriculum approach inasmuch as logical education should begin with an understanding of legal and beneficial drugs and proceed on a grade-level appropriate basis through the illicit and dangerous substances of abuse, thus avoiding the "spot-lighting" and focusing of undue attention (including possible curiosity and seduction) which have been shown to be necessarily inherent weaknesses of our crash educational programs.

II. Health educators and other professionals who work with teachers and the community in the area of drug abuse education should at once begin directing their actions, writing and speaking, to calming the community, especially the parents of school children, encouraging them to see the problem in its proper perspective as a portion of the life style of a drug oriented society. Parents should be encouraged to support their local school districts' efforts in writing and adopting a total health education course; urged to think of ways of offering young people challenging involvement in non-drug oriented activities; in ways of improving the total society for all people; in ways of influencing the mass media to reduce the inflammatory outpour of news and articles on youth and drugs; and in other positive approaches to a problem that is currently suffering from an almost totally negative approach.

Professionals must examine their motives in continuing traditional drug education. It is incumbent on professionals to assess the needs of those they educate, especially the current senior high school student group. It just may be that the high school student population is being super-saturated with drug education, and it is very likely that drug education is being forced on a large segment of high school students, many of whom know everything they are being "taught", and others who have no need for more and more of the information with which professionals, filled with good intentions, continue to bombard them. At this point, after almost five years of saturation drug education, some of it deplorably bad and even dangerous, the real needs are in the lower grades and will be best met by the best efforts of all professionals in producing and teaching the very best course in health education that the human brain can design.

III. More intensive training is needed by teachers to strengthen them as early detectors and case finders. We are not equipping teachers with enough knowledge to enable them to identify the potential abuser, who frequently exhibits personality and character disorders early in his school years.

It then becomes incumbent on school districts and the community to set up workable referral systems which are non-punitive, attractive to young people, and responsive to the complexities of the problem. Obviously, a sound knowledge of health education should be a pre-certification requirement for public school teachers.

IV. Other acute needs are in treatment, especially of the non-addicted and the unmotivated multi-drug abusers. Our present treatment facilities are designed primarily for the motivated heroin addict, and we retreat into cliche when faced with treating the "unmotivated" dependent person. Many approaches must be tried, including group work innovative counseling, and more intensive use of ex-user peers as counselors and group leaders.

These are some of the challenges facing health workers today. An intensive study of the drug problem becomes ultimately a study of society itself. There are obvious and subtle common denominators which seem to be interrelated in all of society's massive problems: environmental health, over-population, slums, and poverty, student unrest and alienation, educational irrelevance, war, and what is referred to as "the drug problem." Many commentators on the problems of society feel nothing short of a re-ordering of social priorities will be effective in solving these complex realities. It is certainly time to address ourselves to their solution. If we are to see a reduction of drug use by our young people, we must begin by facing the issues honestly, maintaining a flexible attitude, and above all, not allow ourselves to hide behind the dogmatic assertations and outmoded positions which have so far accomplished very little. We need new answers to old questions and new questions to which there are no ready answers.

BIBLIOGRAPHY

IX

IX

BIBLIOGRAPHY

A. List of Comprehensive Bibliographies

B. Basic Bibliography of Books and Pamphlets

C. Films

A. Comprehensive Bibliographies

Many very comprehensive bibliographies on drug abuse have been published. Included here are those references which have seemed most helpful to those who work with drug abusers. If more detailed or comprehensive bibliographies are desired, some of the best are:

1. "Annotated List on Drugs," available from the office of Dr. John Thompson, Colorado Department of Education, State Office Building, Denver, 80203.

2. "Bibliography," accompanying N.A.S.P.A. Background Papers

3. "Films, Bibliography, People," a Resource List for Drug Education, prepared by Dr. Richard J. Hardy, and Colorado State College, Greeley, Colorado, March, 1968. The film list from this bibliography is included in this section.

4. "DRUG BIBLIOGRAPHY," San Francisco State College, Education Library. Prepared for the National Training Center on Drug Education held at San Francisco State College, July 20-August 14, 1970, by the Education Library. 33 pages.

B. Bibliography of Books and Pamphlets

1. COLORADO DEPARTMENT OF HEALTH PUBLICATIONS

Facilities and Resources in Colorado for Persons with Alcohol and Drug Problems, Alcoholism and Drug Dependence Division Publication No. 1, Revised 1969. Available to professionals on request.

Facts About Alcohol and Drugs in Colorado. Contains the most reliable statistical data presently available.

2. PAPERBACKS

Drug Abuse: Escape to Nowhere: A Guide for Educators. Philadelphia: Smith, Kline & French Laboratories, in cooperation with the American Association for the Health, Physical Education, and Recreation, a department of the NEA, 1967. $2.00 per copy from NEA, 1201 - 16th St., N.W., Washington, D.C. 20036. Discounts: 2-9 copies, 10%; 10 or more, 20%. Ask for stock #244-07816.

Drug Abuse: A Source Book and Guide for Teachers. California State Department of Education, Sacramento, 1967.

Drugs on the College Campus. A guide for College administrators, by Helen Nowlis, Ph.D. Now available at 95¢ in paperback. Anchor Books Edition by Doubleday. In bookstores, or from Doubleday purchasing Department, Garden City, New York 11530. (In spite of title, contains much general information applicable to the drug problem at all levels. Contains glossary of terms, extensive bibliography, and table of information regarding commonly abused drugs.)

It's Happening (A portrait of the youth scene today), by J. L. Simmons and Barry Winograd. Marc-Laird Publication, Santa Barbara, California, 1967. $1.95.

Facts About Narcotics and Other Dangerous Drugs, by Victor H. Vogel, M.D., and Virginia E. Vogel. Science Research Associates, Inc., 259 East Erie Street, Chicago, Illinois 60611. Reorder No. 5-843. 1 to 24 copies, 80¢ each, 25 to 49 copies, 75¢ each, 50 to 499 copies, 70¢ each.

Facts About Alcohol, by Raymond G. McCarthy, revised by John J. Pasciutti. Science Research Associates, Inc., 259 East Erie Street, Chicago, Illinois 60611. Reorder No. 5-842. 1 to 24 copies, 80¢ each, 25 to 49 copies, 75¢ each, 50 to 499 copies 70¢ each.

The Master Game, (Beyond the Drug Experience) by Robert S. De Ropp. A Delta Book. Dell Publishing Co., Inc. 750 Third Avenue, New York 10017. $1.95. Discusses the glamour drugs of abuse that supposedly promote "higher consciousness" and describes pathways to higher consciousness beyond the drug experience.

Drugs and the Mind, by Robert S. De Ropp. Grove Press, Inc., 80 University Place, New York, New York 10003. Publication #B7, 95¢ each.

This Is It, by Alan W. Watts, Collier Books, $1.50 (Essays on Zen and Spiritual Experience).

Psychotherapy East and West, by Alan W. Watts. Ballantine Books, Inc., 101 Fifth Avenue, New York, N. Y. 10003 (95¢)

3. PAMPHLETS

National Institute of Mental Health Pamphlets:

Narcotics, Some Questions and Answers, publication No. 1827; price, 5¢ each or $3.25 per 100 copies.

LSD, Some Questions and Answers, publication No. 1828; price 5¢ each or $3.25 per 100 copies.

The Up and Down Drugs, Amphetmines and Barbiturates, publication No. 1830; price 5¢ each or $3.25 per 100 copies.

Marihuana, Some Questions and Answers, publication No. 1829; price 5¢ each or $3.75 per 100 copies.

The above NIMH pamphlets, Public Health Service publications may be purchased from the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402

"Ask Alice...." Colorado Public Health Association Pamphlet. Available in quantity at no charge from the National Foundation, 4105 E. Florida Ave., Denver 80222. Phone 757-5131.

What We Can Do About Drug Abuse, by Jules Saltman. Public Affairs Pamphlet No. 390, Public Affairs Pamphlets, 381 Park Ave. South, New York, New York 10016. 1 to 9 copies, 25¢ each, 10 to 99 copies, 20¢ each, 100 to 249 copies, 18¢ each.

Drugs and People, by the Alcoholism and Drug Addiction Research Foundation, Toronto, Ontario, Canada. Published in the United States by Systemedics, Inc., P. O. Box 449, Princeton, New Jersey 08540. Price, 25¢ each, plus 15¢ handling charge.

Drug Abuse: The Empty Life, Smith, Kline & French Laboratories, Philadelphia, PA 19101. [illegible] copies supplied free of charge. Bulk orders (lots [illegible] only) 5¢ each.

4. OTHER MATERIALS

Background Papers [illegible] N.A.S.P.A. A collection of authoritative papers by some of the leading experts in the drug field. Contains section on drug [illegible], a glossary, bibliography, a W.H.O. article on Drug Dependence, a chart of major drugs of abuse, and hundreds of pages of informative information on drugs ($1.00 per set from N.A.S.P.A., 110 Anderson Hall, University of Rochester, Rochester, N.Y. 14627).

Drug Abuse Information - Teacher Resource Material and Drug Facts (a student manual). 282 pages of drug information, a teaching sequence and objectives, jargon, bibliography, glossary, and many articles by authorities on drugs. (Both available for $2.63, postpaid, from Office of Education, County Administration Building, 70 West Hedding Street, San Jose, California 94086).

Parents' Guide of Marijuana,prepared and offered as a public service by Western Electric, Pacific Region, Service Division, Sunnyvale, California 94086.

What YOU Should Know About Drugs and Narcotics, by Alton Blakeslee. The Associated Press, 50 Rockefeller Plaza, New York, New York 10020. (Price: $1.00 each, quantity price (over 100 copies), 60¢ each). Appeared in series in Denver Post in 1969.

Drug Abuse -- A Community Crisis, (a report of a conference on drugs and their abuse) prepared by the Colorado Department of Health. Available at no charge from the Health Education Section, Department of Health.

C. Films

*BEYOND LSD, 25 minutes, color only; $300.00. Sale: Senior High and Adults Film Associates, 11559 Santa Monica Blvd., Los Angeles, Calif. 90025. Sr. High, Parent-Teacher Groups. Examines the "Generation Gap" between adults and young people and its relationship to current drug problems, including alcohol dependency.

THE DANGEROUS DRUGS, 22 minutes, color or B & W, Sale: Color $235.00, B & W $125.00; Rental: Color $12.00 per day, B & W $6.00 per day. The Narcotic Educational Foundation of America, 5055 Sunset Blvd., Los Angeles, Calif. 90027.

*DRUGS AND THE NERVOUS SYSTEM, 20 min., color. Upper elementary, Jr and Sr. High School. Designed to reach young people before they begin to experiment with drugs. Covers aspirin, glue, marijuana, LSD, amphetamines, and barbiturates.

HIDE AND SEEK, 14 minutes, color, sale: $150.00, rental: Inquire Columbia University Press, 1966. Junior high school through college. Center for Mass Communications, Columbia University Press, 1125 Amsterdam Ave., New York, N.Y. 10025.

*HOOKED, 20 minutes, B & W, Sale Churchil Films, 662 N. Robertson Blvd., Los Angeles, California 90069, $125.00. Jr. and Sr. High, Parent Groups. Description of youth (18-25) relating their experiences with being hooked on drugs, reflection of experiences they feel behind them.

THE LOSERS, 31 minutes, B & W, Sale: Carousel Films, Inc., 1501 Broadway, New York, N. Y. 10036, $145.00. Rental: United Church of Christ, Office of Audio-Visuals, 1501 Race Street, Philadelphia PA 19102; Yeshiva University, Audio-Visual Center, 526 West 187th Street, New York, N.Y. 10033; Association Films, Inc., 347 Madison Avenue, New York, N.Y. 10017. Junior through High School.

*THE MIND BENDERS, Color, or B & W, 26 minutes 16mm. High School, College, Adults, Professionals - Young LSD users tell why they took the drug, what it did for them and how it has affected their lives. Three doctors warn of the hazards of taking the drug.

NARCOTICS: A CHALLENGE, 24 minutes, color, or B & W, Sale: color $275.00; B & W $140.00; rental: color $12.50 per day, B & W $7.50 per day. The Narcotic Educational Foundation of America, 1963. For educators on junior and senior high school and college levels. The Narcotic Educational Foundation of America, 5055 Sunset Blvd., Los Angeles, Calif. 90027.

NARCOTICS: THE DECISION, 30 minutes, color or B & W. Sale: Color $265.00, B & W $145.00; rental $15.00. United Research and Training, Inc., 1960. Study guide. High school students. Film Distributors International, 2223 So. Olive Street, Los Angeles, California 90007.

*NARCOTICS -- WHY NOT? 15 minutes Color or B & W, Sale: Charles Cahill and Associates, Inc., P. O. Box 3220, Hollywood, Calif. 90028. Color $175.00, B & W $90.00. Jr. High and older - young people relate how they were introduced to narcotics, what it was like to be under their influence and why they wished they hadn't used them.

*NARCOTICS: PIT OF DESPAIR, 25 minutes, color. Designed to teach perils of narcotics addiction to youngsters. Indicates how inexperienced young people are led to seek refuge in tobacco, alcohol and barbiturates when questionable friends introduce marijuana and opiates. Resultant addiction and problems of withdrawal are included. Jr. and Sr. High School, and adults.

THE RIDDLE, 20 minutes, B & W. Inquiries for rental: Public Affairs, Office of Economic Opportunity, 1200 - 19th Street, N.W., Washington, D.C. 20506. Quest Productions, 1966. Junior High through College.

LSD-25, 27 minutes, color, 16 mm. A documentary presenting scientific facts about LSD with emphasis upon the impact on youth. In this film the drug itself does the talking explaining the harmful effects. Bureau of Drug Abuse, New Custom House, 721 - 19th Street, Denver, Colorado 80202.

LSD: INSIGHT OR INSANITY? The film documents the dangers of the unsupervised, capricious use of LSD and explains what medical scientists know of physiological and psychological effects of the drug. Medical experts point out that LSD does nothing for creativity but merely distorts perception and judgment, often with permanent and damaging effects. Film does not preach, but instead makes young people aware of the possible consequences of taking LSD and helps them to establish their own sense of personal responsibility. Bureau of Drug Abuse Control Room, New Custom House, 721 - 19th Street, Denver, Colorado 80202.

THE SEEKERS, 31 minutes, sound-color, 16 mm. Available from New York State Narcotic Addiction Control Commission, Executive Plaza South, Stuyvesant Plaza, Albany, New York 12203. A documentary in which young people talk to young people about the reasons for using drugs and the results of drug use.

*ACID WORLD (Film Strip), Part 1, 15 minutes, Part 2, 19 minutes, color. Senior High School - Adults. Well photographed exposition of the LSD Drug Experience.

NEW FILMS

The following drug films are among the best of the newer films:

*DISTANT DRUMMER SERIES, a three part documentary prepared under the guidance of the National Institute of Mental Health. The three sections are: "Flowers of Darkness," "The Movable Scene," and "Bridge from No Place." ("Flowers of Darkness," and "Bridge From No Place" are available from the Film Library, Colorado Department of Health.)

MARIJUANA, THE GREAT ESCAPE, the story realistically demonstrates the known effects of marijuana and emphasizes the possibility of psychological dependence. ($265.00) Bailey-Film associates, 11559 Santa Monica Blvd, Los Angeses, CA 90025.

* RAPPING & TRIPPING

"Rapping" consists of an unstructured, unrehearsed discussion between Dr. Anthony Rose and several young people on reasons for starting and stopping drug use.

"Tripping" is a demonstration by Dr. Rose and the youth of various "natural trips" or "non-drug turn-ons", which are presented as alternatives to drug use.

YOU CAN'T GROW A GREEN PLANT IN A CLOSET, Edited from the National Symposium (University of California Medical Center, March, 1968) which assembled may of the country's top drug experts for a contemporary, scientific presentation of Marijuana. (B & W $375.00 color $425.00) Zip Film Distribution company, Mill Valley, CA 94941.

Those interested in critical evaluations of the new drug films should write for a copy of "99 Films on Drugs" to the University of California Extension Media Center, Berkely, CA 94720. Since new material and films are constantly being developed, those who are working in drug education should keep themselves up to date on what is available. Obviously this publication is current only to time of printing.

*These films are available from the Colorado Department of Health on loan basis to residents of Colorado.

HOW TO SECURE: Reservations for films may be made through local health departments, county public health nurse, or from:

Film Library
Colorado Department of Health
Denver, Colorado 80220

Reservations are made in the order in which they are received. The borrower agrees to return the film immediately after showing and pay the return parcel post charge. Do not insure the film as the Department carries a policy which covers the films in transit. Give the Date of Showing -- The Film Library allows ample time for the film to be in transit.

Prices quoted in the preceding information were current as of August 1970. Please check further with film suppliers.